

Title 24-A: MAINE INSURANCE CODE

Chapter 56-A: HEALTH PLAN IMPROVEMENT

ACT HEADING: PL 1997, c. 792, §2 (rpr)

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Maine Revised Statutes
Title 24-A: MAINE INSURANCE CODE
Chapter 56-A: HEALTH PLAN IMPROVEMENT
ACT HEADING: PL 1997, c. 792, §2 (rpr)

Subchapter 1: HEALTH PLAN REQUIREMENTS
HEADING: PL 1997, C. 792, §2 (NEW)

§4301. DEFINITIONS

(REPEALED)

SECTION HISTORY

1995, c. 673, §C1 (NEW). 1995, c. 673, §C2 (AFF). 1997, c. 604, §A1 (AMD). 1999, c. 256, §A1 (AMD). 1999, c. 609, §19 (AMD). 1999, c. 742, §2 (RP). 2001, c. 471, §A28 (RP).

§4301-A. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1999, c. 742, §3 (NEW).]

1. Adverse health care treatment decision. "Adverse health care treatment decision" means a health care treatment decision made by or on behalf of a carrier offering or renewing a health plan denying in whole or in part payment for or provision of otherwise covered services requested by or on behalf of an enrollee. "Adverse health care treatment decision" includes a rescission determination and an initial coverage eligibility determination, consistent with the requirements of the federal Affordable Care Act.

[2011, c. 364, §20 (AMD) .]

2. Authorized representative. "Authorized representative" means:

A. A person to whom an enrollee has given express written consent to represent the enrollee in an external review; [1999, c. 742, §3 (NEW).]

B. A person authorized by law to provide consent to request an external review for an enrollee; or [1999, c. 742, §3 (NEW).]

C. A family member of an enrollee or an enrollee's treating health care provider when the enrollee is unable to provide consent to request an external review. [1999, c. 742, §3 (NEW).]

[1999, c. 742, §3 (NEW) .]

3. Carrier. "Carrier" means:

A. An insurance company licensed in accordance with this Title to provide health insurance; [1999, c. 742, §3 (NEW).]

B. A health maintenance organization licensed pursuant to chapter 56; [1999, c. 742, §3 (NEW) .]

C. A preferred provider arrangement administrator registered pursuant to chapter 32; [1999, c. 742, §3 (NEW) .]

D. A fraternal benefit society, as defined by section 4101; [1999, c. 742, §3 (NEW) .]

E. A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24; [1999, c. 742, §3 (NEW).]

F. A multiple-employer welfare arrangement licensed pursuant to chapter 81; [2011, c. 364, §21 (AMD).]

G. A self-insured employer subject to state regulation as described in section 2848-A; or [2011, c. 364, §21 (AMD).]

H. Notwithstanding any other provision of this Title, an entity offering coverage in this State that is subject to the requirements of the federal Affordable Care Act. [2011, c. 364, §22 (NEW).]

An employer exempted from the applicability of this chapter under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) is not considered a carrier.

[2011, c. 364, §§21, 22 (AMD) .]

4. Clinical peer. "Clinical peer" means a physician or other licensed health care practitioner who holds a nonrestricted license in a state of the United States in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, or other physician or health care practitioner with demonstrable expertise necessary to review a case.

[1999, c. 742, §3 (NEW) .]

5. Enrollee. "Enrollee" means an individual who is enrolled in a health plan or a managed care plan.

[1999, c. 742, §3 (NEW) .]

6. Health care treatment decision. "Health care treatment decision" means a decision regarding diagnosis, care or treatment when medical services are provided by a health plan, or a benefits decision involving determinations regarding medically necessary health care, preexisting condition determinations and determinations regarding experimental or investigational services.

[2001, c. 288, §1 (AMD) .]

7. Health plan. "Health plan" means a plan offered or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan, other than a plan that provides only accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care or other limited benefit coverage not subject to the requirements of the federal Affordable Care Act. A plan that is subject to the requirements of the federal Affordable Care Act and offered in this State by a carrier, including, but not limited to, a qualified health plan offered on an American Health Benefit Exchange or a SHOP Exchange established pursuant to the federal Affordable Care Act, is a health plan for purposes of this chapter.

[2011, c. 364, §23 (AMD) .]

8. Independent review organization. "Independent review organization" means an entity that conducts independent external reviews of adverse health care treatment decisions.

[1999, c. 742, §3 (NEW) .]

9. Managed care plan. "Managed care plan" means a plan offered or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan through:

A. Arrangements with selected providers to furnish health care services; and [1999, c. 742, §3 (NEW) .]

B. Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan. [1999, c. 742, §3 (NEW).]

A return to work program developed for the management of workers' compensation claims may not be considered a managed care plan.

[1999, c. 742, §3 (NEW) .]

10. Medically appropriate health care.

[2001, c. 288, §2 (RP) .]

10-A. Medically necessary health care. "Medically necessary health care" means health care services or products provided to an enrollee for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

A. Consistent with generally accepted standards of medical practice; [2001, c. 288, §3 (NEW) .]

B. Clinically appropriate in terms of type, frequency, extent, site and duration; [2001, c. 288, §3 (NEW) .]

C. Demonstrated through scientific evidence to be effective in improving health outcomes; [2001, c. 288, §3 (NEW) .]

D. Representative of "best practices" in the medical profession; and [2001, c. 288, §3 (NEW) .]

E. Not primarily for the convenience of the enrollee or physician or other health care practitioner. [2001, c. 288, §3 (NEW) .]

[2001, c. 288, §3 (NEW) .]

11. Medical necessity.

[2001, c. 288, §4 (RP) .]

12. Ordinary care. "Ordinary care" means, in the case of a carrier, the degree of care that a carrier of ordinary prudence would use under the same or similar circumstances. For a person who is an agent of a carrier, "ordinary care" means the degree of care that a person of ordinary prudence would use under the same or similar circumstances.

[1999, c. 742, §3 (NEW) .]

13. Participating provider. "Participating provider" means a licensed or certified provider of health care services, including mental health services, or health care supplies that has entered into an agreement with a carrier to provide those services or supplies to an individual enrolled in a managed care plan.

[1999, c. 742, §3 (NEW) .]

14. Peer-reviewed medical literature. "Peer-reviewed medical literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals that present supporting data that the proposed use of a drug or device is safe and effective.

[1999, c. 742, §3 (NEW) .]

15. Plan sponsor. "Plan sponsor" means an employer, association, public agency or any other entity providing a health plan.

[1999, c. 742, §3 (NEW) .]

16. Provider. "Provider" means a practitioner or facility licensed, accredited or certified to perform specified health care services consistent with state law.

[1999, c. 742, §3 (NEW) .]

16-A. Provider profiling program. "Provider profiling program" means a program that uses provider data in order to rate or rank provider quality, cost or efficiency of care by the use of a grade, star, tier, rating or any other form of designation that provides an enrollee with an incentive to use a designated provider based on quality, cost or efficiency of care.

[2013, c. 383, §3 (AMD) .]

17. Religious nonmedical provider. "Religious nonmedical provider" means a provider who provides only religious nonmedical treatment or religious nonmedical nursing care.

[1999, c. 742, §3 (NEW) .]

18. Special condition. "Special condition" means a condition or disease that is life-threatening, degenerative or disabling and requires specialized medical care over a prolonged period of time.

[1999, c. 742, §3 (NEW) .]

19. Specialist. "Specialist" means an appropriately licensed and credentialed health care provider with specialized training and clinical expertise.

[1999, c. 742, §3 (NEW) .]

20. Standard reference compendia. "Standard reference compendia" means:

A. The United States Pharmacopeia Drug Information or information published by its successor organization; or [1999, c. 742, §3 (NEW) .]

B. The American Hospital Formulary Service Drug Information or information published by its successor organization. [1999, c. 742, §3 (NEW) .]

[1999, c. 742, §3 (NEW) .]

SECTION HISTORY

1999, c. 742, §3 (NEW). 2001, c. 288, §§1-4 (AMD). 2007, c. 199, Pt. B, §1 (AMD). 2009, c. 439, Pt. B, §1 (AMD). 2011, c. 364, §§20-23 (AMD). 2013, c. 383, §3 (AMD).

§4302. REPORTING REQUIREMENTS

To offer or renew a health plan in this State, a carrier must comply with the following requirements. [2007, c. 199, Pt. B, §2 (AMD) .]

1. Description of plan. A carrier shall provide to prospective enrollees and participating providers, and to members of the public and nonparticipating providers upon request, information on the terms and conditions of the plan to enable those persons to make informed decisions regarding their choice of plan. A carrier shall provide this information annually to current enrollees, participating providers and the

superintendent. This information must be presented in a standardized format acceptable to the superintendent. In adopting rules or developing standardized reporting formats, the superintendent shall consider the nature of the health plan and the extent to which rules or standardized formats are appropriate to the plan. All written and oral descriptions of the health plan must be truthful and must use appropriate and objective terms that are easy to understand. These descriptions must be consistent with standards developed for supplemental insurance coverage under the United States Social Security Act, Title XVIII, 42 United States Code, Sections 301 to 1397 (1988). Descriptions of plans under this subsection must be standardized so that enrollees may compare the attributes of the plans. After a carrier has provided the required information, the annual information requirement under this subsection may be satisfied by the provision of any amendments to the materials on an annual basis. Specific items that must be included in a description are as follows:

A. Coverage provisions, benefits and any exclusions by category of service, type of provider and, if applicable, by specific service, including but not limited to the following types of exclusions and limitations:

- (1) Health care services excluded from coverage;
- (2) Health care services requiring copayments or deductibles paid by enrollees;
- (3) Restrictions on access to a particular provider type;
- (4) Health care services that are or may be provided only by referral; and
- (5) Childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics; [2009, c. 439, Pt. A, §2 (AMD).]

B. Any prior authorization or other review requirements, including preauthorization review, concurrent review, postservice review, postpayment review and any procedures that may result in the enrollee being denied coverage or not being provided a particular service; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

C. A general description of the methods used to compensate providers, including capitation and methods in which providers receive compensation based upon referrals, utilization or cost criteria; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

D. An explanation of how health plan limitations affect enrollees, including information on enrollee financial responsibilities for payment of coinsurance or other noncovered or out-of-plan services and limits on preexisting conditions and waiting periods; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

E. The terms under which the health plan may be renewed by the plan members or enrollees, including any reservation by the health plan of any right to increase premiums; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

F. A statement as to when benefits cease in the event of nonpayment of the prepaid or periodic premium and the effect of nonpayment upon the enrollees who are hospitalized or undergoing treatment for an ongoing condition; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

G. A description of the manner in which the plan addresses the following: the provision of appropriate and accessible care in a timely fashion; an effective and timely grievance process and the circumstances in which an enrollee may obtain a 2nd opinion; timely determinations of coverage issues; confidentiality of medical records; and written copies of coverage decisions that are not explicit in the health plan agreement. The description must also include a statement explaining the circumstances under which health status may be considered in making coverage decisions in accordance with state and federal laws and that enrollees may refuse particular treatments without jeopardizing future treatment; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

H. Procedures an enrollee must follow to obtain drugs and medicines that are subject to a plan list or plan formulary, if any; a description of the formulary; and a description of the extent to which an enrollee will be reimbursed for the cost of a drug that is not on a plan list or plan formulary. Enrollees may request additional information related to specific drugs that are not on the drug formulary; [1999, c. 742, §4 (AMD).]

I. Information on where and in what manner health care services may be obtained; [1999, c. 742, §4 (AMD).]

J. A description of the independent external review procedures and the circumstances under which an enrollee is entitled to independent external review as required by this chapter; [2009, c. 439, Pt. B, §2 (AMD).]

K. A description of the requirements for enrollees to obtain coverage of routine costs of clinical trials and information on the manner in which enrollees not eligible to participate in clinical trials may qualify for the compassionate use program of the federal Food and Drug Administration for use of investigational drugs pursuant to 21 Code of Federal Regulations, Section 312.34, as amended; and [2009, c. 439, Pt. B, §3 (AMD).]

L. A description of a provider profiling program that may be a part of the health plan, including the location of provider performance ratings in the plan materials or on a publicly accessible website, information explaining the provider rating system and the basis upon which provider performance is measured, the limitations of the data used to measure provider performance, the process for selecting providers and a conspicuous written disclaimer explaining the provider performance ratings should only be used as a guide for choosing a provider and that enrollees should consult their current provider before making a decision about their health care based on a provider rating. [2009, c. 439, Pt. B, §4 (NEW).]

[2009, c. 439, Pt. A, §2 (AMD); 2009, c. 439, Pt. B, §§2-4 (AMD) .]

2. Plan complaint; adverse decisions; prior authorization statistics. A carrier shall provide annually to the superintendent information for each health plan that it offers or renews on plan complaints, adverse decisions and prior authorization statistics. This statistical information must contain, at a minimum:

A. The ratio of the number of complaints received by the plan to the total number of enrollees, reported by type of complaint and category of enrollee; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

B. The ratio of the number of adverse decisions issued by the plan to the number of complaints received, reported by category; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

C. The ratio of the number of prior authorizations denied by the plan to the number of prior authorizations requested, reported by category; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

D. The ratio of the number of successful enrollee appeals to the total number of appeals filed; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

E. The percentage of disenrollments by enrollees and providers from the health plan within the previous 12 months and the reasons for the disenrollments. With respect to enrollees, the information provided in this paragraph must differentiate between voluntary and involuntary disenrollments; and [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

F. Enrollee satisfaction statistics, including provider-to-enrollee ratio by geographic region and medical specialty and a report on what actions, if any, the carrier has taken to improve complaint handling and eliminate the causes of valid complaints. [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

[2007, c. 199, Pt. B, §3 (AMD) .]

3. Acceptable methods of providing information. A carrier may meet any of the reporting requirements set forth in this section by providing information in conformity with the requirements of the federal Health Maintenance Organization Act of 1973, 42 United States Code, Sections 280c and 300e to 300e-17 (1988), or any other applicable state or federal law or any accrediting organization recognized by the superintendent, as long as the superintendent finds that the information is substantially similar to the information required by this section and is presented in a format that provides a meaningful comparison between health plans. When the superintendent determines that it is feasible and appropriate, the information required by this section must be provided by geographic region, age, gender and type of employer or group. With respect to geographical breakdown, the information must be provided in a manner that permits comparisons between urban and rural areas.

[1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF) .]

4. Claims data. By February 1st of each year, a carrier that provides only administrative services for a plan sponsor shall annually file with the superintendent for the most recent complete calendar year for all covered individuals in the State the total number of claims paid for each plan sponsor and the total dollar amount of claims paid for each plan sponsor.

[2001, c. 457, §23 (NEW) .]

5. Annual report; claims for diagnosis and treatment of Lyme disease and other tick-borne illnesses. By February 1st of each year, all carriers shall file with the superintendent for the most recent calendar year for all covered individuals in the State the total claims made for the diagnosis and treatment of Lyme disease and other tick-borne illnesses. The filing must include information on the number of claims made for the diagnosis and treatment of Lyme disease and other tick-borne illnesses, the total dollar amount of those claims, the number of claim denials and the reasons for those denials, the number and outcome of internal appeals and the number of external appeals related to the diagnosis and treatment of Lyme disease and other tick-borne illnesses. The superintendent shall compile from all carriers this data in an annual report and submit the report by March 15th of each year to the joint standing committee of the Legislature having jurisdiction over health insurance matters. The superintendent shall consult with the Department of Health and Human Services, Maine Center for Disease Control and Prevention to determine any additional information to be collected from carriers, beginning with data for calendar year 2011.

[2009, c. 494, §5 (AMD) .]

6. Reporting required pursuant to the Affordable Care Act. Notwithstanding any other requirements of this Title, a carrier shall provide to the Secretary of the United States Department of Health and Human Services, and make available to the public when required by federal law, any information required by the federal Affordable Care Act. Carriers shall provide the information to the superintendent upon request.

[2011, c. 364, §24 (NEW) .]

SECTION HISTORY

1995, c. 673, §C1 (NEW). 1995, c. 673, §C2 (AFF). 1999, c. 742, §§4,5 (AMD). 2001, c. 457, §23 (AMD). 2007, c. 199, Pt. B, §§2, 3 (AMD). 2007, c. 561, §2 (AMD). 2009, c. 439, Pt. A, §2 (AMD). 2009, c. 439, Pt. B, §§2-4 (AMD). 2009, c. 494, §5 (AMD). 2011, c. 364, §24 (AMD).

§4303. PLAN REQUIREMENTS

A carrier offering or renewing a health plan in this State must meet the following requirements.
[2007, c. 199, Pt. B, §4 (AMD).]

1. Demonstration of adequate access to providers. A carrier offering or renewing a managed care plan shall provide to its members reasonable access to health care services. A carrier may provide incentives to members to use designated providers based on cost or quality, but may not require members to use designated providers of health care services.

A. [2007, c. 199, Pt. B, §5 (AMD); T.24-A, §4303, sub-1, ¶A (RP).]

B. [2011, c. 90, Pt. F, §7 (RP).]

C. [2011, c. 90, Pt. F, §7 (RP).]

[2011, c. 90, Pt. F, §7 (RPR) .]

2. Credentialling. The credentialling of providers by a carrier is governed by this subsection.

A. The granting of credentials must be based on objective standards that are available to providers upon application for credentialling. A carrier shall consult with appropriately qualified health care professionals in developing its credentialling standards. [1997, c. 163, §1 (AMD).]

B. All credentialling decisions, including those granting, denying or withdrawing credentials, must be in writing. The provider must be provided with all reasons for the denial of an application for credentialling or the withdrawal of credentials. A withdrawal of credentials must be treated as a provider termination and is subject to the requirements of subsection 3-A. [1997, c. 163, §1 (AMD).]

C. A carrier shall establish and maintain an appeal procedure, including the provider's right to a hearing, for dealing with provider concerns relating to the denial of credentialling for not meeting the objective credentialling standards of the plan and the contractual relationship between the carrier and the provider. The superintendent shall determine whether the process provided by a carrier is fair and reasonable. This procedure must be specified in every contract between a carrier and a provider or between a carrier and a provider network if a carrier does not contract with providers individually. [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

D. A carrier shall make credentialling decisions, including those granting or denying credentials, within 60 days of receipt of a completed credentialling application from a provider. The time period for granting or denying credentials may be extended upon written notification from the carrier within 60 days following submission of a completed application stating that information contained in the application requires additional time for verification. All credentialling decisions must be made within 180 days of receipt of a completed application. For the purposes of this paragraph, an application is completed if the application includes all of the information required by the uniform credentialling application used by carriers and providers in this State, such attachments to that application as required by the carrier at the time of application and all corrections required by the carrier. A carrier shall review the entire application before returning it to the provider for corrections with a comprehensive list of all corrections needed at the time the application is first returned to the provider. A carrier may not require that a provider have a home address within the State before accepting an application. [2003, c. 108, §1 (NEW).]

E. [2013, c. 383, §4 (RP).]

[2013, c. 383, §4 (AMD) .]

3. Provider's right to advocate for medically appropriate care. A carrier offering or renewing a managed care plan may not terminate or otherwise discipline a participating provider because the provider advocates for medically appropriate health care. A carrier may not restrict a provider from disclosing to any enrollee any information the provider determines appropriate regarding the nature of treatment and any risks or alternatives to treatment, the availability of other therapy, consultations or tests or the decision of any plan to authorize or deny health care services or benefits.

A. For the purposes of this section, "to advocate for medically appropriate health care" means to discuss or recommend a course of treatment to an enrollee; to appeal a managed care plan's decision to deny payment for a service pursuant to an established grievance or appeal procedure; or to protest a decision, policy or practice that the provider, consistent with the degree of learning and skill ordinarily possessed by reputable providers, reasonably believes impairs the provider's ability to provide medically appropriate health care to the provider's patients. [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

B. Nothing in this subsection may be construed to prohibit a plan from making a determination not to pay for a particular medical treatment or service or to enforce reasonable peer review or utilization review protocols. [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

[2007, c. 199, Pt. B, §6 (AMD) .]

3-A. Termination of participating providers. A carrier offering or renewing a managed care plan may not terminate or nonrenew a contract with a participating provider unless the carrier provides the provider with a written explanation prior to the termination or nonrenewal of the reasons for the proposed contract termination or nonrenewal and provides an opportunity for a review or hearing in accordance with this subsection. The existence of a termination without cause provision in a carrier's contract with a provider does not supersede the requirements of this subsection. This subsection does not apply to termination cases involving imminent harm to patient care, a final determination of fraud by a governmental agency, a final disciplinary action by a state licensing board or other governmental agency that impairs the ability of a provider to practice. A review or hearing of proposed contract termination must meet the following requirements.

A. The notice of the proposed contract termination or nonrenewal provided by the carrier to the participating provider must include:

- (1) The reason or reasons for the proposed action in sufficient detail to permit the provider to respond;
- (2) Reference to the evidence or documentation underlying the carrier's decision to pursue the proposed action. A carrier shall permit a provider to review this evidence and documentation upon request;
- (3) Notice that the provider has the right to request a review or hearing before a panel appointed by the carrier;
- (4) A time limit of not less than 30 days from the date the provider receives the notice within which a provider may request a review or hearing; and
- (5) A time limit for a hearing date that must be not less than 30 days after the date of receipt of a request for a hearing.

Termination or nonrenewal may not be effective earlier than 60 days from the receipt of the notice of termination or nonrenewal. [1997, c. 163, §2 (NEW).]

B. A hearing panel must be composed of at least 3 persons appointed by the carrier and one person on the hearing panel must be a clinical peer in the same discipline and the same or similar specialty of the provider under review. A hearing panel may be composed of more than 3 persons if the number of clinical peers on the hearing panel constitutes 1/3 or more of the total membership of the panel. [1997, c. 163, §2 (NEW).]

C. A hearing panel shall render a written decision on the proposed action in a timely manner. This decision must be either the reinstatement of the provider by the carrier, the provisional reinstatement of the provider subject to conditions established by the carrier or the termination or nonrenewal of the provider. [1997, c. 163, §2 (NEW).]

D. A decision by a hearing panel to terminate or nonrenew a contract with a provider may not become effective less than 60 days after the receipt by the provider of the hearing panel's decision or until the termination date in the provider's contract, whichever is earlier. [1997, c. 163, §2 (NEW).]

[2007, c. 199, Pt. B, §7 (AMD) .]

3-B. Prohibition on financial incentives. A carrier offering or renewing a managed care plan may not offer or pay any type of material inducement, bonus or other financial incentive to a participating provider to deny, reduce, withhold, limit or delay specific medically necessary health care services covered under the plan to an enrollee. This subsection may not be construed to prohibit pilot projects authorized pursuant to section 4320-H or to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or risk-sharing agreements that are made with respect to providers or groups of providers or that are made with respect to groups of enrollees.

[2011, c. 1, §41 (COR) .]

4. Grievance procedure for enrollees. A carrier offering or renewing a health plan in this State shall establish and maintain a grievance procedure that meets standards developed by the superintendent to provide for the resolution of claims denials or other matters by which enrollees are aggrieved.

A. The grievance procedure must include, at a minimum, the following:

- (1) Notice to the enrollee promptly of any claim denial or other matter by which enrollees are likely to be aggrieved, stating the basis for the decision, the right to file a grievance, the procedure for doing so and the time period in which the grievance must be filed;
- (2) Timelines within which grievances must be processed, including expedited processing for exigent circumstances. Timelines must be sufficiently expeditious to resolve grievances promptly. Decisions for second level grievance reviews as defined by bureau rules must be issued within 30 calendar days if the insured has not requested the opportunity to appear in person before authorized representatives of the health carrier;
- (3) Procedures for the submission of relevant information and enrollee participation;
- (4) Provision to the aggrieved party of a written statement upon the conclusion of any grievance process, setting forth the reasons for any decision. The statement must include notice to the aggrieved party of any subsequent appeal or external review rights, the procedure and time limitations for exercising those rights and notice of the right to file a complaint with the Bureau of Insurance and the toll-free telephone number of the bureau; and
- (5) Decision-making by one or more individuals not previously involved in making the decision subject to the grievance. [2007, c. 199, Pt. B, §9 (AMD).]

B. In any appeal under the grievance procedure in which a professional medical opinion regarding a health condition is a material issue in the dispute, the aggrieved party is entitled to an independent 2nd opinion, paid for by the plan, of a provider of the same specialty participating in the plan. If a provider of the same specialty does not participate in the plan, then the 2nd opinion must be given by a nonparticipating provider. [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

C. In any appeal under the grievance procedure, the carrier shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by an enrollee who is deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an enrollee who is visually impaired to allow the enrollee to exercise the enrollee's right to an appeal under this subsection. [1999, c. 742, §9 (NEW).]

D. Notwithstanding this subsection, a group health plan sponsored by an agricultural cooperative association located outside of this State that provides health insurance coverage to members of one or more agricultural cooperative associations located within this State may employ a grievance procedure for enrollees in the group health plan that meets the requirements of the state in which the group health plan is located if enrollees in the group health plan that reside in this State have the right to independent external review in accordance with section 4312 following any adverse health care treatment decision. Any difference in the grievance procedure requirements between those of the state in which the group health plan is located and those of this State must be limited to the number of days required for notification of prior authorization for nonemergency services and the number of days required for the issuance of a decision following the filing of an appeal of an adverse health care treatment decision. Enrollees in the group health plan that reside in this State must be notified as to the grievance procedure used by the group health plan and their right to independent external review in accordance with section 4312. [2003, c. 309, §1 (NEW) .]

E. Health plans subject to the requirements of the federal Affordable Care Act must comply with federal claims and appeal requirements, including, but not limited to, the requirement that benefits for an ongoing course of treatment may not be reduced or terminated without advance notice and an opportunity for advance review, consistent with the requirements of the federal Affordable Care Act. [2011, c. 364, §25 (NEW) .]

[2011, c. 364, §25 (AMD) .]

5. Identification of services provided by certified nurse practitioners and certified nurse midwives.

All claims for coverage of services provided by certified nurse practitioners and certified nurse midwives must identify the certified nurse practitioners and certified nurse midwives who provided those services. A carrier offering or renewing a health plan in this State shall assign identification numbers or codes to certified nurse practitioners and certified nurse midwives who provide covered services for enrollees covered under that plan. A claim submitted for payment to a carrier by a health care provider or facility must include the identification number or code of the certified nurse practitioner or certified nurse midwife who provided the service and may not be submitted using the identification number or code of a physician or other health care provider who did not provide the covered service.

[2007, c. 199, Pt. B, §10 (AMD) .]

6. Standing referrals to specialists. A carrier shall establish and maintain a procedure to allow an enrollee with a special condition requiring ongoing care from a specialist to receive a standing referral to a specialist participating in the carrier's network for treatment of that special condition. If the carrier or the enrollee's primary care provider, in consultation with the carrier's medical director, determines that a standing referral is appropriate, the carrier shall ensure that the enrollee receives such a referral to a specialist. If a specialist able to treat the enrollee's special condition does not participate in the carrier's network, then the carrier shall ensure that the enrollee receives a standing referral to a nonparticipating specialist. A standing referral must be made pursuant to a treatment plan approved by the carrier's medical director in consultation with the enrollee's primary care provider. After the standing referral is made, the specialist is authorized to provide health care services to the enrollee in the same manner as the enrollee's primary care provider, subject to the terms of the treatment plan.

[1999, c. 742, §10 (NEW) .]

7. Continuity of care. If a contract between a carrier and a provider is terminated or benefits or coverage provided by a provider is terminated because of a change in the terms of provider participation in a health plan and an enrollee is undergoing a course of treatment from the provider at the time of termination, the carrier shall provide continuity of care in accordance with the requirements in paragraphs A to C. This section does not apply to provider terminations exempt from the requirements of subsection 3-A.

If a managed care contract for the provision of health insurance coverage between a plan sponsor and a carrier is replaced within the meaning of section 2849 with a different managed care contract and a health care provider that has been providing health care services to an enrollee is not in the replacement carrier's network, the replacement carrier shall provide continuity of care in accordance with the requirements in paragraphs A to C in the same manner as if the provider had been terminated from the replacement carrier's network as of the date of the policy replacement, but only with respect to benefits that are covered under the replacement contract.

A. The carrier shall notify an enrollee of the termination of the provider's contract at least 60 days in advance of the date of termination. When circumstances related to the termination render such notice impossible, the carrier shall provide affected enrollees as much notice as is reasonably possible. The notice given to the enrollee must include instructions on obtaining an alternate provider and must offer the carrier's assistance with obtaining an alternate provider and ensuring that there is no inappropriate disruption in the enrollee's ongoing treatment. [1999, c. 742, §10 (NEW).]

B. The carrier shall permit the enrollee to continue or be covered, with respect to the course of treatment with the provider, for a transitional period of at least 60 days from the date of notice to the enrollee of the provider's termination except that if an enrollee is in the 2nd trimester of pregnancy at the time of the provider's termination and the provider is treating the enrollee during the pregnancy, the transitional period must extend through the provision of postpartum care directly related to the pregnancy. [1999, c. 742, §10 (NEW).]

C. A carrier may make coverage of continued treatment by a provider under paragraph B conditional upon the provider's agreeing to the following terms and conditions.

(1) The provider agrees to accept reimbursement from the carrier at rates applicable prior to the start of the transitional period as payment in full and not to impose cost-sharing with respect to the enrollee in an amount that would exceed the cost-sharing that could have been imposed if the contract between the carrier and the provider had not been terminated.

(2) The provider agrees to adhere to the quality assurance standards of the carrier responsible for payment and to provide the carrier necessary medical information related to the care provided.

(3) The provider agrees otherwise to adhere to the carrier's policies and procedures, including procedures regarding referrals and prior authorizations and providing services pursuant to any treatment plan approved by the carrier. [1999, c. 742, §10 (NEW).]

[1999, c. 742, §10 (NEW) .]

7-A. Continuity of prescriptions. If an enrollee has been undergoing a course of treatment with a prescription drug by prior authorization of a carrier and the enrollee's coverage with one carrier is replaced with coverage from another carrier pursuant to section 2849-B, the replacement carrier shall honor the prior authorization for that prescription drug and provide coverage in the same manner as the previous carrier until the replacement carrier conducts a review of the prior authorization for that prescription drug with the enrollee's prescribing provider. Policies must include a notice of the right to request a review with the enrollee's provider, and the replacing carrier must honor the prior carrier's authorization for a period not to exceed 6 months if the enrollee's provider participates in the review and requests the prior authorization be continued. The replacing carrier is not required to provide benefits for conditions or services not otherwise covered under the replacement policy, and cost sharing may be based on the copayments and coinsurance requirements of the replacement policy.

[2009, c. 439, Pt. F, §1 (NEW) .]

8. Maximum allowable charges. All policies, contracts and certificates executed, delivered and issued by a carrier under which the insured or enrollee may be subject to balance billing when charges exceed a maximum considered usual, customary and reasonable by the carrier or that contain contractual language of similar import must be subject to the following.

A. If benefits for covered services are limited to a maximum amount based on any combination of usual, customary and reasonable charges or other similar method, the carrier must:

- (1) Clearly disclose that the insured or enrollee may be subject to balance billing as a result of claims adjustment; and
- (2) Provide a toll-free number that an insured or enrollee may call prior to receiving services to determine the maximum allowable charge permitted by the carrier for a specified service. [2001, c. 410, Pt. B, §5 (NEW).]

B. The carrier must provide to the superintendent on request complete information on the methodology and specific data used by the carrier or any 3rd party on behalf of the carrier in adjusting any claim submitted by or on behalf of the insured or enrollee. In considering the reasonableness of the methodology for calculating maximum allowable charges, the superintendent shall consider whether the methodology takes into account relevant data specific to this State if there is sufficient data to constitute a representative sample of charge data for the same or comparable service. [2001, c. 410, Pt. B, §5 (NEW).]

[2001, c. 410, Pt. B, §5 (NEW).]

8-A. Protection from balance billing by participating providers. An enrollee's responsibility for payment under a managed care plan must be limited as provided in this subsection.

A. The terms of a managed care plan must provide that the enrollee's responsibility for the cost of covered health care rendered by participating providers is limited to the cost-sharing provisions expressly disclosed in the contract, such as deductibles, copayments and coinsurance, and that if the enrollee has paid the enrollee's share of the charge as specified in the plan, the carrier shall hold the enrollee harmless from any additional amount owed to a participating provider for covered health care. [2011, c. 238, Pt. A, §1 (NEW).]

B. Every provider agreement with a participating provider must be in writing and must set forth that if the carrier fails to pay for health care services as set forth in the contract, the enrollee is not liable to the provider for any sums owed by the carrier. [2011, c. 238, Pt. A, §1 (NEW).]

C. A participating provider may not collect or attempt to collect any charge from an enrollee for covered health care beyond the amount permitted by the terms of the plan, notwithstanding the carrier's insolvency, the carrier's failure to pay the amount owed by the carrier, any other breach by the carrier of the provider agreement or the failure of the provider agreement to include the written hold harmless provision required by paragraph B. [2011, c. 238, Pt. A, §1 (NEW).]

[2011, c. 238, Pt. A, §1 (NEW).]

9. (REALLOCATED TO T. 24-A, §4303, sub-§11) Absolute discretion clauses.

[2003, c. 1, §21 (RAL); 2003, c. 110, §1 (NEW).]

9. Notice of amendments to provider agreements. A carrier offering or renewing a health plan in this State shall notify a participating provider of a proposed amendment to a provider agreement at least 60 days prior to the amendment's proposed effective date. If an amendment that has substantial impact on the rights and obligations of providers is made to a manual, policy or procedure document referenced in the provider agreement, such as material changes to fee schedules or material changes to procedural coding rules specified in the manual, policy or procedure document, the carrier shall provide 60 days' notice to the provider. After the 60-day notice period has expired, the amendment to a manual, policy or procedure document becomes effective and binding on both the carrier and the provider subject to any applicable termination provisions in

the provider agreement, except that the carrier and provider may mutually agree to waive the 60-day notice requirement. This subsection may not be construed to limit the ability of a carrier and provider to mutually agree to the proposed change at any time after the provider has received notice of the proposed amendment.

[2007, c. 199, Pt. B, §11 (AMD) .]

10. Limits on retrospective denials. A carrier offering a health plan in this State may not impose on any provider any retrospective denial of a previously paid claim or any part of that previously paid claim unless:

A. The carrier has provided the reason for the retrospective denial in writing to the provider; and
[2003, c. 218, §9 (NEW) .]

B. The time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months. The retrospective denial of a previously paid claim may be permitted beyond 12 months from the date of payment only for the following reasons:

- (1) The claim was submitted fraudulently;
- (2) The claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim;
- (3) The health care services identified in the claim were not delivered by the provider;
- (4) The claim payment was for services covered by Title XVIII, Title XIX or Title XXI of the Social Security Act;
- (5) The claim payment is the subject of adjustment with another insurer, administrator or payor; or
- (6) The claim payment is the subject of legal action. [2007, c. 106, §1 (AMD) .]

For purposes of this subsection, "retrospective denial of a previously paid claim" means any attempt by a carrier to retroactively collect payments already made to a provider with respect to a claim by requiring repayment of such payments, reducing other payments currently owed to the provider, withholding or setting off against future payments or reducing or affecting the future claim payments to the provider in any other manner. The provider has 6 months from the date of notification under this subsection to determine whether the insured has other appropriate insurance that was in effect on the date of service. Notwithstanding the terms of the provider agreement, the carrier shall allow for the submission of a claim that was previously denied by another insurer because of the insured's transfer or termination of coverage.

[2007, c. 106, §1 (AMD) .]

11. (REALLOCATED FROM T. 24-A, §4303, sub-§9) Absolute discretion clauses. The use and enforcement of an absolute discretion clause is governed by this subsection.

A. A policy, contract, certificate or agreement offered, delivered, issued or renewed for delivery in this State by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services may not contain a provision purporting to reserve sole or absolute discretion to the carrier to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this State. [2003, c. 1, §21 (RAL) .]

B. A carrier may not enforce a provision in a policy, contract, certificate or agreement that was offered, delivered or issued for delivery in this State and has been continued or renewed by a group policy holder or individual enrollee in this State that purports to reserve sole or absolute discretion to the carrier to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this State. [2003, c. 1, §21 (RAL) .]

[2003, c. 1, §21 (RAL) .]

12. Publication of policies by carriers. A carrier must publish at least 5 individual health plans with the highest level of enrollment and at least 5 small group health plans with the highest level of enrollment on the carrier's publicly accessible website in a manner that will allow consumers to review the coverage offered under each policy. The policies posted on the website must be updated when changes are made to the policies by the carrier. The appearance of the policy on the website must duplicate the appearance of a paper copy of the policy. The bureau shall provide a link from its website to each carrier's website. A carrier must review annually which policies to post and make any necessary changes on its website. A carrier must post the required policies on its website within 90 days after the effective date of this subsection.

[2009, c. 439, Pt. A, §3 (NEW) .]

13. Explanation of benefits. A carrier offering an individual expense-incurred health plan to residents of this State or an expense-incurred group health plan to an employer in this State shall provide individual policyholders and group certificate holders with clear written explanations of benefit documents in response to the filing of any claim providing for coverage of hospital or medical expenses. The explanation of benefits must include all of the following information:

- A. The date of service; [2009, c. 439, Pt. A, §4 (NEW) .]
- B. The provider of the service; [2009, c. 439, Pt. A, §4 (NEW) .]
- C. An identification of the service for which the claim is made; [2009, c. 439, Pt. A, §4 (NEW) .]
- D. Any amount the insured is obligated to pay under the policy for copayment or coinsurance; [2009, c. 439, Pt. A, §4 (NEW) .]
- E. A telephone number and address where the insured may obtain clarification of the explanation of benefits; [2009, c. 439, Pt. A, §4 (NEW) .]
- F. A notice of appeal rights; and [2009, c. 439, Pt. A, §4 (NEW) .]
- G. A notice of the right to file a complaint with the bureau after exhausting any appeals under a carrier's internal appeals process. [2009, c. 439, Pt. A, §4 (NEW) .]

The superintendent shall establish by rule the minimum information and standards for explanation of benefits forms used by carriers, taking into consideration any input from stakeholders and any national standards for explanation of benefits forms. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. This subsection applies to any explanation of benefits form issued on or after January 1, 2010.

[2009, c. 439, Pt. A, §4 (NEW) .]

14. Policy terms. The superintendent may by rule define standard policy terms that must be used in all policies issued by carriers offering health plans in the State. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2009, c. 439, Pt. A, §5 (NEW) .]

15. Uniform explanation of coverage documents and standardized definitions. A carrier offering a health plan in this State shall:

- A. Provide to applicants, enrollees and policyholders or certificate holders a summary of benefits and an explanation of coverage that accurately describe the benefits and coverage under the applicable plan or coverage. A summary of benefits and an explanation of coverage must conform with the requirements of the federal Affordable Care Act; and [2011, c. 364, §26 (NEW) .]
- B. Use standard definitions of insurance-related and medical-related terms in connection with health insurance coverage as required by the federal Affordable Care Act. [2011, c. 364, §26 (NEW) .]

(Subsection 15 as enacted by PL 2011, c. 451, §1 is REALLOCATED TO TITLE 24-A, SECTION 4303, SUBSECTION 17)

[2011, c. 364, §26 (NEW) .]

16. Language and culture. All notices to applicants, enrollees and policyholders or certificate holders subject to the requirements of the federal Affordable Care Act must be provided in a culturally and linguistically appropriate manner consistent with the requirements of the federal Affordable Care Act.

[2011, c. 364, §27 (NEW) .]

17. (REALLOCATED FROM T. 24-A, §4303, sub-§15) Prohibition on "most favored nation" clauses. Participation agreements between carriers and providers are governed by this subsection.

A. A participation agreement between a carrier and a provider may not include a provision, commonly referred to as a "most favored nation" clause, that:

- (1) Prohibits, or grants the carrier an option to prohibit, the provider from entering into a participation agreement with another carrier to provide services at a lower price than the payment specified in the participation agreement;
- (2) Requires, or grants the carrier an option to require, the provider to accept a lower payment in the event the provider agrees to provide services to any other carrier at a lower price;
- (3) Requires, or grants the carrier an option of, termination or renegotiation of the existing participation agreement in the event the provider agrees to provide services to any other carrier at a lower price; or
- (4) Requires the provider to disclose its reimbursement rates from other carriers. [2011, c. 1, §42 (RAL) .]

B. The superintendent may grant a waiver to paragraph A on application by either a carrier or a provider. A carrier or provider requesting a waiver for more than one participation agreement must file a separate application for each requested waiver. The superintendent may grant a waiver only after issuing a finding that the inclusion in the participation agreement of a most favored nation clause as described in paragraph A is not anticompetitive. A carrier or provider requesting a waiver may request a hearing on the application for a waiver in accordance with section 229. The findings and decision of the superintendent are final agency actions for the purposes of Title 5, chapter 375, subchapter 7 and, notwithstanding section 236, subsection 2, may be appealed regardless of whether a hearing was held. The superintendent's review under this paragraph is limited to the most favored nation clause, and any decision under this paragraph is for purposes of this subsection only and may not be construed as a finding or decision regarding the legality of the provision under other applicable law. [2011, c. 1, §42 (RAL) .]

C. Prior to the issuance of the superintendent's findings and decision on an application for a waiver pursuant to this subsection, any contract, proposal or draft legal instrument submitted to the superintendent in an application for a waiver is not a public record for the purposes of Title 1, chapter 13, except that the name and business address of the parties to an application for a waiver are public information. After the issuance of the superintendent's findings and decision, the superintendent may disclose any information that the superintendent determines is not proprietary information. For the purposes of this paragraph, "proprietary information" means information that is a trade secret or production, commercial or financial information the disclosure of which would impair the competitive position of the carrier or provider submitting the information and would make available information not otherwise publicly available. [2011, c. 1, §42 (RAL) .]

D. A carrier may not discriminate or retaliate against a provider for filing or opposing an application for a waiver under this subsection. [2011, c. 1, §42 (RAL) .]

E. A provider may not discriminate or retaliate against a carrier for filing or opposing an application for a waiver under this subsection. [2011, c. 1, §42 (RAL).]

F. For the purposes of this subsection, the factors the superintendent may consider in determining whether to grant a waiver based on a finding that the inclusion of a most favored nation clause as described in paragraph A is not anticompetitive include, but are not limited to:

- (1) Any reduction or limit on competition among carriers or providers;
- (2) The impact on quality and availability of health care services, including the geographic distribution of providers;
- (3) The size of the provider and the type of any specialty;
- (4) The market share of the carrier and the provider;
- (5) The impact on the price and stability of health insurance and health care services to consumers; and
- (6) The impact on reimbursement rates in the provider marketplace. [2011, c. 1, §42 (RAL).]

[2011, c. 1, §42 (RAL).]

18. Provider contract requirements. A carrier offering a health plan must meet the requirements of this subsection with respect to a contract offered by the carrier to a provider, including a contract offered through a preferred provider arrangement, as defined in section 2671, subsection 7. This subsection does not apply to dental or vision plans.

A. If the contract for a preferred provider arrangement includes a reference to policies or procedures to which a contracting provider would be bound, all such policies and procedures must be provided to the provider for review in an easily accessible manner upon the provider's request at the time the contract is offered. [2013, c. 399, §1 (NEW).]

B. Upon the provider's request at the time a contract for a preferred provider arrangement is offered, the following must be provided to a provider for review:

- (1) The fee schedule or, if there is not a fee schedule for one or more of the services covered under the contract, the terms under which payment is determined. A carrier may require a provider to execute a nondisclosure agreement covering the information provided under this subparagraph; and
- (2) The identity of all carriers for which the provider is agreeing to provide services to health plan enrollees. [2013, c. 399, §1 (NEW).]

C. As a condition of participation in one of the carrier's preferred provider arrangements, a contract offered by a carrier may not require a provider to participate in any other carrier's network subsequently offered by the carrier or by a carrier's preferred provider arrangement. [2013, c. 399, §1 (NEW).]

D. Without the provider's prior written consent, a provider's contractual participation in a carrier's preferred provider arrangement may not:

- (1) Subject the provider to health plan payor requirements or fee schedules that materially differ from the terms of the provider's contract with the carrier, unless those materially different terms are set out in writing in a separate section of the contract, such as an exhibit or amendment; or
- (2) Permit the terms of the provider's existing preferred provider arrangement contract to be superseded by a carrier's subsequent contract with a health plan payor. [2013, c. 399, §1 (NEW).]

E. A preferred provider arrangement contract may not require a provider providing a service to an enrollee under a health plan included in the provider's contract to obtain preauthorization if the enrollee's health plan does not require prior authorization as a condition of coverage. [2013, c. 399, §1 (NEW) .]

F. Explanation of remittance advices or comparable documents, whether in paper or electronic form, that accompany and identify payment of a provider's claims under a carrier's contract, including contracts offered through a preferred provider arrangement, must identify the administrator and payor of the provider's claims and include contact information. [2013, c. 399, §1 (NEW) .]

The requirements of this subsection do not apply to a carrier offering a health plan with respect to preferred provider arrangement contracts with a hospital or pharmacy.

[2013, c. 399, §1 (NEW) .]

19. Information about provider networks. A carrier offering a managed care plan shall prominently disclose to applicants, prospective enrollees and enrollees information about the carrier's provider network for the applicable managed care plan, including whether there are hospitals, health care facilities, physicians or other providers not included in the plan's network and any differences in an enrollee's financial responsibilities for payment of covered services to a participating provider and to a provider not included in a provider network. The superintendent may adopt rules that set forth the manner, content and required disclosure of the information in accordance with this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2013, c. 535, §1 (NEW) .]

SECTION HISTORY

1995, c. 673, Pt. C, §1 (NEW). 1995, c. 673, Pt. C, §2 (AFF). 1997, c. 163, §§1, 2 (AMD). 1999, c. 396, §5 (AMD). 1999, c. 396, §7 (AFF). 1999, c. 742, §§6-10 (AMD). 2001, c. 288, §5 (AMD). 2001, c. 410, Pt. B, §5 (AMD). RR 2003, c. 1, §21 (COR). 2003, c. 108, §1 (AMD). 2003, c. 110, §1 (AMD). 2003, c. 218, §9 (AMD). 2003, c. 309, §1 (AMD). 2003, c. 469, Pt. E, §20 (AMD). 2003, c. 689, Pt. B, §6 (REV). 2007, c. 106, §1 (AMD). 2007, c. 199, Pt. B, §§4-11 (AMD). 2009, c. 357, §1 (AMD). 2009, c. 439, Pt. A, §§3-5 (AMD). 2009, c. 439, Pt. B, §5 (AMD). 2009, c. 439, Pt. F, §1 (AMD). 2009, c. 652, Pt. A, §33 (AMD). RR 2011, c. 1, §§41, 42 (COR). 2011, c. 90, Pt. F, §7 (AMD). 2011, c. 238, Pt. A, §1 (AMD). 2011, c. 270, §1 (AMD). 2011, c. 364, §§25-27 (AMD). 2011, c. 451, §1 (AMD). 2011, c. 451, §2 (AFF). 2013, c. 383, §4 (AMD). 2013, c. 399, §1 (AMD). 2013, c. 535, §1 (AMD).

§4303-A. PROVIDER PROFILING PROGRAMS

1. Disclosure. At least 60 days prior to using or publicly disclosing the results of the provider profiling program, a carrier with a provider profiling program shall disclose to providers the methodologies, criteria, data and analysis used to evaluate provider quality, performance and cost, including but not limited to unit cost, price and cost-efficiency ratings. For the purposes of this subsection, the disclosure of data is satisfied by the provision by a carrier of a description of the data used in the evaluation, the source of the data, the time period subject to evaluation and, if applicable, the types of claims used in the evaluation including any adjustments to the data and exclusion from the data.

[2013, c. 383, §5 (NEW) .]

2. Provider profile. A carrier shall create and share with providers their provider profile at least 60 days prior to using or publicly disclosing the results of the provider profiling program.

[2013, c. 383, §5 (NEW) .]

3. Request for data. A provider may request a copy of its data within 30 days of the carrier's disclosure to a provider as required by subsection 2, and, upon request from a provider, a carrier shall provide to that provider the data associated with the requesting provider and all adjustments to the data used to evaluate that provider as part of the carrier's provider profiling program. The bureau shall adopt rules to establish requirements for the disclosure of data by a carrier to a provider in accordance with this subsection. The bureau shall provide in the rules for a time and manner of disclosure consistent with a carrier's ability to adopt, revise and develop an effective provider profiling program.

[2013, c. 383, §5 (NEW) .]

4. Appeals. A carrier shall establish a process that affords a provider the opportunity to review and dispute its provider profiling result within 30 days of being provided with its provider profile pursuant to subsection 2. The appeal process must:

A. Afford the provider the opportunity to correct material errors, submit additional information for consideration and seek review of data and performance ratings; [2013, c. 383, §5 (NEW) .]

B. Afford the provider the opportunity to review any information or evaluation prepared by a 3rd party and used by the carrier as part of its provider profiling program; however, if the 3rd party provides the right to review and correct that data, any appeal pursuant to this paragraph is limited to whether the carrier accurately portrayed the information and not to the underlying determination made by the 3rd party; and [2013, c. 383, §5 (NEW) .]

C. Allow the provider to request reconsideration of its provider profiling result and submit supplemental information, including information demonstrating any computational or data errors. [2013, c. 383, §5 (NEW) .]

[2013, c. 383, §5 (NEW) .]

5. Out-of-network providers. If a carrier has a provider profiling program that includes out-of-network providers, a carrier must meet the requirements of this section with regard to an out-of-network provider as well as for a provider in a carrier's network.

[2013, c. 383, §5 (NEW) .]

6. Rules. The bureau shall adopt rules necessary to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2013, c. 383, §5 (NEW) .]

SECTION HISTORY

2013, c. 383, §5 (NEW) .

§4303-B. DISCLOSURE RELATED TO PROVIDER NETWORKS

1. Disclosure. Upon request, a carrier shall provide to a provider to which the carrier has decided not to offer the opportunity to participate or that the carrier has decided not to include as a participating provider in any of the carrier's provider networks a written explanation of the reason for the carrier's decision. The

written explanation provided by the carrier must indicate whether the reason for not offering the provider the opportunity to contract or for not including the provider in any network was related to the provider's performance with respect to quality, cost or cost-efficiency.

[2013, c. 535, §2 (NEW) .]

2. No right of action. A provider has no right of action as the result of a disclosure made in accordance with this section.

[2013, c. 535, §2 (NEW) .]

SECTION HISTORY

2013, c. 535, §2 (NEW).

§4304. UTILIZATION REVIEW

The following requirements apply to health plans doing business in this State that require prior authorization by the plan of health care services or otherwise subject payment of health care services to review for clinical necessity, appropriateness, efficacy or efficiency. A carrier offering or renewing a health plan subject to this section that contracts with other entities to perform utilization review on the carrier's behalf is responsible for ensuring compliance with this section and chapter 34. [2007, c. 199, Pt. B, §12 (AMD).]

1. Requirements for medical review or utilization review practices. A carrier must appoint a medical director who is responsible for reviewing and approving the carrier's policies governing the clinical aspects of coverage determinations by any health plan that it offers or renews. A carrier's medical review or utilization review practices must be governed by the standard of medically necessary health care as defined in this chapter.

[2007, c. 199, Pt. B, §13 (AMD) .]

2. Prior authorization of nonemergency services. Requests by a provider for prior authorization of a nonemergency service must be answered by a carrier within 2 business days. Both the provider and the enrollee on whose behalf the authorization was requested must be notified by the carrier of its determination. If the information submitted is insufficient to make a decision, the carrier shall notify the provider within 2 business days of the additional information necessary to render a decision. If the carrier determines that outside consultation is necessary, the carrier shall notify the provider and the enrollee for whom the service was requested within 2 business days. The carrier shall make a good faith estimate of when the final determination will be made and contact the enrollee and the provider as soon as practicable. Notification requirements under this subsection are satisfied by written notification postmarked within the time limit specified.

[1999, c. 742, §12 (AMD) .]

3. Background information; affirmative duty of provider. A provider has an affirmative duty to submit to the carrier the background information necessary for the carrier to complete its review and render a decision within the time period required in subsection 2. If the provider needs additional time to submit that required information, the provider must inform the carrier in a timely manner. Nothing in this section requires a provider to submit confidential information without a signed consent from the enrollee.

[1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF) .]

4. Revocation of prior authorization. When prior approval for a service or other covered item is granted, a carrier may not retrospectively deny coverage or payment for the originally approved service unless fraudulent or materially incorrect information was provided at the time prior approval for the service was granted.

[1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF) .]

5. Emergency services. When conducting utilization review or making a benefit determination for emergency services, a carrier shall provide benefits for emergency services consistent with the requirements of any applicable bureau rule.

[1999, c. 742, §13 (NEW) .]

6. Notice. A notice issued by a carrier or its contracted utilization review entity in response to a request by or on behalf of an insured or enrollee for authorization of medical services that advises that the requested service has been determined to be medically necessary must also advise whether the service is covered under the policy or contract under which the insured or enrollee is covered. Nothing in this subsection requires a carrier to provide coverage for services performed when the insured or enrollee is no longer covered by the health plan.

[2001, c. 410, Pt. B, §6 (NEW) .]

SECTION HISTORY

1995, c. 673, §C1 (NEW). 1995, c. 673, §C2 (AFF). 1999, c. 742, §§11-13 (AMD). 2001, c. 288, §6 (AMD). 2001, c. 410, §B6 (AMD). 2007, c. 199, Pt. B, §§12, 13 (AMD).

§4305. QUALITY OF CARE

A carrier offering or renewing a health plan that subjects payment of benefits for otherwise covered services to review for clinical necessity, appropriateness, efficacy or efficiency must meet the following requirements relating to quality of care. [2007, c. 199, Pt. B, §14 (AMD).]

1. Internal quality assurance program. A health plan must have an ongoing quality assurance program for the health care services provided or reimbursed by the health plan.

[1995, c. 673, §1 (NEW); 1995, c. 673, §2 (AFF) .]

2. Written standards. The standards of quality of care must be described in a written document, which must be available for examination by the superintendent or by the Department of Health and Human Services.

[1995, c. 673, §1 (NEW); 1995, c. 673, §2 (AFF); 2003, c. 689, Pt. B, §6 (REV) .]

3. Coverage decisions. Following a determination that a particular service is covered, a carrier may not deny payment for that service based on the enrollee's age, nature of disability or degree of medical dependency.

[1995, c. 673, §1 (NEW); 1995, c. 673, §2 (AFF) .]

SECTION HISTORY

1995, c. 673, §C1 (NEW). 1995, c. 673, §C2 (AFF). 1999, c. 742, §14 (AMD). 2003, c. 689, §B6 (REV). 2007, c. 199, Pt. B, §14 (AMD).

§4306. ENROLLEE CHOICE OF PRIMARY CARE PROVIDER

A carrier offering or renewing a managed care plan shall allow enrollees to choose their own primary care providers, as allowed under the managed care plan's rules, from among the panel of participating providers made available to enrollees under the managed care plan's rules. A carrier shall allow physicians, including, but not limited to, pediatricians and physicians who specialize in obstetrics and gynecology, and certified nurse practitioners who have been approved by the State Board of Nursing to practice advanced practice registered nursing without the supervision of a physician pursuant to Title 32, section 2102, subsection 2-A to serve as primary care providers for managed care plans. A carrier is not required to contract with certified nurse practitioners or physicians as primary care providers in any manner that exceeds the access and provider network standards required in this chapter or chapter 56, or any rules adopted pursuant to those chapters. A carrier shall allow enrollees in a managed care plan to change primary care providers without good cause at least once annually and to change with good cause as necessary. When an enrollee fails to choose a primary care provider, the carrier may assign the enrollee a primary care provider located in the same geographic area in which the enrollee resides. [2011, c. 364, §28 (AMD).]

SECTION HISTORY

1995, c. 673, §C1 (NEW). 1995, c. 673, §C2 (AFF). 1999, c. 396, §6 (AMD). 1999, c. 396, §7 (AFF). 1999, c. 742, §15 (AMD). 2007, c. 199, Pt. B, §15 (AMD). 2011, c. 364, §28 (AMD).

§4306-A. PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE

Notwithstanding any other requirements of this Title, a carrier offering a health plan in this State subject to the requirements of the federal Affordable Care Act: [2011, c. 364, §29 (NEW).]

1. Authorization or referral not required. May not require authorization or referral by the carrier or any other person, including a primary care provider, in the case of a female enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional as described in the federal Affordable Care Act who specializes in obstetrics or gynecology. The health care professional shall agree to otherwise adhere to the health plan's or carrier's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the carrier; and

[2011, c. 364, §29 (NEW) .]

2. Treated as primary care. Shall treat the provision of obstetrical and gynecological care by a participating health care professional as described in the federal Affordable Care Act who specializes in obstetrics or gynecology, pursuant to subsection 1, as authorized by the primary care provider and the authorization of related obstetrical and gynecological items and services by that professional as the authorization of the primary care provider.

[2011, c. 364, §29 (NEW) .]

SECTION HISTORY

2011, c. 364, §29 (NEW).

§4307. CONSTRUCTION

Nothing in this chapter may be construed to: [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

1. Purchase services with own funds. Prohibit an individual from purchasing any health care services with that individual's own funds, whether these services are covered within the individual's benefit package or from another health care provider or plan, except as otherwise provided by federal or state law;

[1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF) .]

2. Additional benefits. Prohibit any plan sponsor from providing additional coverage for benefits, rights or protections not set out in this chapter;

[1999, c. 742, §16 (AMD) .]

3. Provider participation. Require a carrier to admit to a managed care plan a provider willing to abide by the terms and conditions of the managed care plan; or

[1999, c. 742, §16 (AMD) .]

4. Treatment by religious nonmedical providers. With respect to coverage of treatment by religious nonmedical providers:

A. Restrict or limit the right of a carrier to include a religious nonmedical provider as a participating provider in a managed care plan; [1999, c. 742, §17 (NEW) .]

B. Require a carrier to:

(1) Utilize medically based eligibility standards or criteria in deciding provider status of religious nonmedical providers;

(2) Use medical professionals or criteria to decide enrollee access to religious nonmedical providers;

(3) Utilize medical professionals or criteria in making decisions in internal or external appeals regarding coverage for care by religious nonmedical providers; or

(4) Compel an enrollee to undergo a medical examination or test as a condition of receiving coverage for treatment by a religious nonmedical provider; or [1999, c. 742, §17 (NEW) .]

C. Require a carrier to exclude religious nonmedical providers because the providers do not provide medical or other required data, if such data is inconsistent with the religious nonmedical treatment or nursing care provided by the provider. [1999, c. 742, §17 (NEW) .]

[1999, c. 742, §17 (NEW) .]

SECTION HISTORY

1995, c. 673, §C1 (NEW). 1995, c. 673, §C2 (AFF). 1999, c. 742, §§16,17 (AMD) .

§4308. INDEMNIFICATION

A contract between a carrier offering or renewing a health plan and a provider for the provision of services to enrollees may not require the provider to indemnify the carrier for any expenses and liabilities, including, without limitation, judgments, settlements, attorney's fees, court costs and any associated charges incurred in connection with a claim or action brought against the health plan based on the carrier's own fault. Nothing in this section may be construed to remove responsibility of a carrier or provider for expenses or liabilities caused by the carrier's or provider's own negligent acts or omissions or intentional misconduct.

[2007, c. 199, Pt. B, §16 (AMD) .]

1. Indemnification.

[1999, c. 742, §18 (RP) .]

SECTION HISTORY

1995, c. 673, §C1 (NEW). 1995, c. 673, §C2 (AFF). 1999, c. 742, §18 (RPR). 2007, c. 199, Pt. B, §16 (AMD).

§4309. ADOPTION OF RULES

The superintendent shall adopt rules and establish standards for health plans in order to carry out the purposes of this chapter. Rules adopted pursuant to this chapter are major substantive rules as defined in Title 5, chapter 375, subchapter II-A. [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

SECTION HISTORY

1995, c. 673, §C1 (NEW). 1995, c. 673, §C2 (AFF).

§4309-A. COMPLIANCE WITH THE AFFORDABLE CARE ACT

1. Carriers. A carrier shall comply with all applicable requirements of the federal Affordable Care Act.

[2011, c. 364, §30 (NEW) .]

2. Superintendent. The superintendent may enforce and administer this section through all powers provided under this Title and Title 24. The superintendent may adopt and amend rules, establish standards and enforce federal statutes and regulations in order to carry out the purposes of the federal Affordable Care Act. Rules or amendments adopted pursuant to this subsection, including amendments to major substantive rules, are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2011, c. 364, §30 (NEW) .]

SECTION HISTORY

2011, c. 364, §30 (NEW).

§4310. ACCESS TO CLINICAL TRIALS

1. Qualified enrollee. An enrollee is eligible for coverage for participation in an approved clinical trial if the enrollee meets the following conditions:

A. The enrollee has a life-threatening illness for which no standard treatment is effective; [1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF).]

B. The enrollee is eligible to participate according to the clinical trial protocol with respect to treatment of such illness; [1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF).]

C. The enrollee's participation in the trial offers meaningful potential for significant clinical benefit to the enrollee; and [1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF).]

D. The enrollee's referring physician has concluded that the enrollee's participation in such a trial would be appropriate based upon the satisfaction of the conditions in paragraphs A, B and C. [1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF).]

[1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF) .]

2. Coverage. A carrier may not deny a qualified enrollee participation in an approved clinical trial or deny, limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. For the purposes of this section, "routine patient costs" does not include the costs of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

[1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF) .]

3. Payment. A carrier shall provide payment for routine patient costs but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial. In the case of covered items and services, the carrier shall pay participating providers at the agreed upon rate and pay nonparticipating providers at the same rate the carrier would pay for comparable services performed by participating providers.

[1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF) .]

4. Approved clinical trial. For the purposes of this section, "approved clinical trial" means a clinical research study or clinical investigation approved and funded by the federal Department of Health and Human Services, National Institutes of Health or a cooperative group or center of the National Institutes of Health.

[1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF) .]

5. Application. The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §31 (NEW) .]

SECTION HISTORY

1999, c. 742, §19 (NEW). 1999, c. 742, §21 (AFF). 2003, c. 517, §B31 (AMD).

§4311. ACCESS TO PRESCRIPTION DRUGS

1. Formulary. If a health plan provides coverage for prescription drugs but the coverage limits such benefits to drugs included in a formulary, a carrier shall:

A. Ensure participation of participating physicians and pharmacists in the development of the formulary; and [1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF).]

B. Provide exceptions to the formulary limitation when a nonformulary alternative is medically indicated, consistent with the utilization review standards in section 4304. [1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF).]

[1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF) .]

2. Coverage of approved drugs and medical devices. A carrier that provides coverage for prescription drugs and medical devices may not deny coverage of a prescribed drug or medical device on the basis that the use of the drug or device is investigational if the intended use of the drug or device is included in the labeling authorized by the federal Food and Drug Administration or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature.

[1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF) .]

3. Construction. This section may not be construed to require a carrier to provide coverage of prescription drugs or medical devices.

[1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF) .]

4. Application. The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §32 (NEW) .]

SECTION HISTORY

1999, c. 742, §19 (NEW). 1999, c. 742, §21 (AFF). 2003, c. 517, §B32 (AMD) .

§4312. INDEPENDENT EXTERNAL REVIEW

An enrollee has the right to an independent external review of a carrier's adverse health care treatment decision made by or on behalf of a carrier offering or renewing a health plan in accordance with the requirements of this section. An enrollee's failure to obtain authorization prior to receiving an otherwise covered service may not preclude an enrollee from exercising the enrollee's rights under this section.

[2007, c. 199, Pt. B, §17 (AMD) .]

1. Request for external review. An enrollee or the enrollee's authorized representative shall make a written request for external review of an adverse health care treatment decision to the bureau. Except as provided in subsection 2, an enrollee may not make a request for external review under a group plan until the enrollee has exhausted all levels of a carrier's internal grievance procedure and may not make a request for external review under an individual plan until the enrollee has exhausted one level of a carrier's internal grievance procedure. A request for external review must be made within 12 months of the date an enrollee has received a final adverse health care treatment decision under a carrier's internal grievance procedure. An enrollee may not be required to pay any filing fee as a condition of processing a request for external review.

[2011, c. 364, §31 (AMD) .]

2. Expedited request for external review. An enrollee or an enrollee's authorized representative is not required to exhaust a carrier's internal grievance procedure in accordance with subsection 1 before filing a request for external review if:

A. The carrier has failed to make a decision on an internal grievance within the time period required or has otherwise failed to adhere to all the requirements applicable to the appeal pursuant to state and federal law or the enrollee has applied for expedited external review at the same time as applying for an expedited internal appeal; [2011, c. 364, §32 (AMD) .]

B. The carrier and the enrollee mutually agree to bypass the internal grievance procedure; [1999, c. 742, §19 (NEW) .]

C. The life or health of the enrollee is in serious jeopardy; [2011, c. 364, §32 (AMD) .]

D. The enrollee has died; or [2011, c. 364, §32 (AMD) .]

E. The adverse health care treatment decision to be reviewed concerns an admission, availability of care, a continued stay or health care services when the claimant has received emergency services but has not been discharged from the facility that provided the emergency services. [2011, c. 364, §32 (NEW) .]

[2011, c. 364, §32 (AMD) .]

3. Notice to enrollees. A carrier shall notify an enrollee of the enrollee's right to request an external review in large type and easy-to-read language in a conspicuous location on the written notice of an adverse health care treatment decision. The notice must include:

- A. A description of the external review procedure and the requirements for making a request for external review; [1999, c. 742, §19 (NEW).]
- B. A statement informing an enrollee how to request assistance in filing a request for external review from the carrier; [1999, c. 742, §19 (NEW).]
- C. A statement informing an enrollee of the right to attend the external review, submit and obtain supporting material relating to the adverse health care treatment decision under review, ask questions of any representative of the carrier and have outside assistance; and [1999, c. 742, §19 (NEW).]
- D. A statement informing an enrollee of the right to seek assistance or file a complaint with the bureau and the toll-free number of the bureau. [1999, c. 742, §19 (NEW).]

[1999, c. 742, §19 (NEW) .]

4. Independent external review; bureau oversight. The bureau shall oversee the external review process required under this section and shall contract with approved independent review organizations to conduct an external review and render an external review decision. At a minimum, an independent review organization approved by the bureau shall ensure the selection of qualified and impartial reviewers who are clinical peers with respect to the adverse health care treatment decision under review and who have no professional, familial or financial conflict of interest relating to a carrier, enrollee, enrollee's authorized representative or health care provider involved in the external review.

[1999, c. 742, §19 (NEW) .]

5. Independent external review decision; timelines. An external review decision must be made in accordance with the following requirements.

A. In rendering an external review decision, the independent review organization must give consideration to the appropriateness of the requested covered service based on the following:

- (1) All relevant clinical information relating to the enrollee's physical and mental condition, including any competing clinical information;
- (2) Any concerns expressed by the enrollee concerning the enrollee's health status; and
- (3) All relevant clinical standards and guidelines, including, but not limited to, those standards and guidelines relied upon by the carrier or the carrier's utilization review entity. [1999, c. 742, §19 (NEW).]

B. An external review decision must be issued in writing and must be based on the evidence presented by the carrier and the enrollee or the enrollee's authorized representative. An enrollee may submit and obtain evidence relating to the adverse health care treatment decision under review, attend the external review, ask questions of any representative of the carrier present at the external review and use outside assistance during the review process at the enrollee's own expense. [1999, c. 742, §19 (NEW) .]

C. Except as provided in paragraph D, an external review decision must be rendered by an independent review organization within 30 days of receipt of a completed request for external review from the bureau. [1999, c. 742, §19 (NEW).]

D. An external review decision must be made as expeditiously as an enrollee's medical condition requires but in no event more than 72 hours after receipt of a completed request for external review if the time frame for review required under paragraph C would seriously jeopardize the life or health of the enrollee or would jeopardize the enrollee's ability to regain maximum function. [1999, c. 742, §19 (NEW) .]

E. The carrier shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by an enrollee who is deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an enrollee who is visually impaired to allow the enrollee to exercise the enrollee's right to an external review under this section. [1999, c. 742, §19 (NEW).]

[1999, c. 742, §19 (NEW) .]

6. Binding nature of decision. An external review decision is binding on the carrier. An enrollee or the enrollee's authorized representative may not file a request for a subsequent external review involving the same adverse health care treatment decision for which the enrollee has already received an external review decision pursuant to this section. An external review decision made under this section is not considered final agency action pursuant to Title 5, chapter 375, subchapter II.

[1999, c. 742, §19 (NEW) .]

7. Funding. A carrier against which a request for external review has been filed shall pay the cost of the independent external review to the bureau.

[1999, c. 742, §19 (NEW) .]

7-A. Confidentiality. Except as provided in this subsection, all records of the bureau or an independent review organization relating to an external review request or external review proceeding are confidential and not a public record under Title 1, chapter 13.

A. A party to an external review may obtain from the independent review organization a transcript or recording of the external review hearing and a copy of any evidence introduced by the opposing party. [2013, c. 274, §1 (NEW).]

B. The superintendent shall disseminate to the Legislature and to the public aggregate information related to external reviews conducted by independent review organizations on an annual basis, including:

- (1) The number of external review requests by carrier, the number of decisions in favor of the enrollee, the number of decisions upholding the carrier's benefit determination and the number of external review requests resolved prior to the issuance of a decision; and
- (2) The categories of external review requests by carrier. The categories may not include personally identifiable information or specific medical condition. The categories must include, but are not limited to, medical necessity, out-of-network referrals, inpatient care, behavioral health, prescription drugs and experimental or investigational treatment. [2013, c. 274, §1 (NEW).]

[2013, c. 274, §1 (NEW) .]

8. Rules. The bureau may adopt rules necessary to carry out the requirements of this section, including, without limitation, criteria for determining when multiple denials of benefits to the same enrollee for the same or similar reasons are considered the same adverse health care treatment decision. Notwithstanding the requirements of section 4309, rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[1999, c. 742, §19 (NEW) .]

9. Rights. This section may not be construed to remove or limit any legal rights or remedies of an enrollee or other person under state or federal law, including the right to file judicial actions to enforce rights.

[1999, c. 742, §19 (NEW) .]

10. Applicability. Decisions relating to the following health care services are subject to review pursuant to other review processes provided by applicable federal or state law and may not be reviewed pursuant to this section:

- A. Health care services provided through Medicaid, Medicare, Title XXI of the Social Security Act or services provided under these programs through contracted health care providers; [1999, c. 742, §19 (NEW).]
- B. Health care services provided to inmates by the Department of Corrections; or [1999, c. 742, §19 (NEW).]
- C. Health care services provided pursuant to a health plan not subject to regulation by the State. [1999, c. 742, §19 (NEW).]

[1999, c. 742, §19 (NEW) .]

SECTION HISTORY

1999, c. 742, §19 (NEW). 2007, c. 199, Pt. B, §17 (AMD). 2011, c. 364, §§31, 32 (AMD). 2013, c. 274, §1 (AMD).

§4313. CARRIER LIABILITY; CAUSE OF ACTION

1. Duty of ordinary care; cause of action. An enrollee may maintain a cause of action against a carrier offering or renewing a health plan in accordance with the following.

- A. A carrier has the duty to exercise ordinary care when making health care treatment decisions that affect the quality of the diagnosis, care or treatment provided to an enrollee and is liable for damages as provided in this section for harm to an enrollee proximately caused by the failure of the carrier or its agents to exercise such ordinary care. [1999, c. 742, §19 (NEW).]
- B. A carrier is also liable for damages as provided in this section for harm to an enrollee proximately caused by the health care treatment decisions made by its agents who are acting on the carrier's behalf and over whom the carrier exercised control or influence in the health care treatment decisions that result in the failure to exercise ordinary care. [1999, c. 742, §19 (NEW).]

[2007, c. 199, Pt. B, §18 (AMD) .]

2. Exhaustion of internal and external review. An enrollee may not maintain a cause of action under this section unless the enrollee or the enrollee's representative:

- A. Has exhausted all levels of the carrier's internal grievance procedure in accordance with this chapter; and [1999, c. 742, §19 (NEW).]
- B. Has completed the independent external review process required under section 4312. [1999, c. 742, §19 (NEW).]

[1999, c. 742, §19 (NEW) .]

3. Limitation on cause of action. An action under this section must be initiated within 3 years from the earlier of the date of issuance of the written external review decision under section 4312 or the date of issuance of the underlying adverse first-level appeal or first-level grievance determination notice.

[1999, c. 742, §19 (NEW) .]

4. Jurisdiction; notice and filing. The Superior Court has original jurisdiction over a cause of action under this section. The requirements for notice and filing of a cause of action under this section are governed by the Maine Rules of Civil Procedure.

[1999, c. 742, §19 (NEW) .]

5. Corporate practice of medicine. Section 4222, subsection 3 or any other law in this State prohibiting a carrier from practicing medicine or being licensed to practice medicine may not be asserted as a defense by a carrier in any action brought pursuant to this section.

[1999, c. 742, §19 (NEW) .]

6. No obligation for benefits. This section does not create any obligation on the part of a carrier to provide an enrollee any health care treatment or service that is not covered by the enrollee's health plan policy or contract.

[1999, c. 742, §19 (NEW) .]

7. Admissibility of external review decision. An external review decision is admissible in an action under this section.

[1999, c. 742, §19 (NEW) .]

8. Affirmative defense. It is an affirmative defense to any action asserted against a carrier under this section that the carrier or any agent for whose conduct the carrier is liable did not control, influence or participate in the health care treatment decision.

[1999, c. 742, §19 (NEW) .]

9. Damages. In a cause of action under this section, the award of damages must be made in accordance with this subsection.

A. Actual or compensatory damages may be awarded. [1999, c. 742, §19 (NEW) .]

B. Noneconomic damages awarded may not exceed \$400,000. [1999, c. 742, §19 (NEW) .]

C. Punitive damages may not be awarded. [1999, c. 742, §19 (NEW) .]

[1999, c. 742, §19 (NEW) .]

10. Professional negligence. This section does not create any new or additional liability on the part of a carrier for harm caused to an enrollee that is attributable to the professional negligence of a treating physician or other health care practitioner.

[1999, c. 742, §19 (NEW) .]

11. Employer liability. This section does not create any liability on the part of an employer that assumes risk on behalf of its employees or an employer group purchasing organization.

[1999, c. 742, §19 (NEW) .]

12. Exemption. This section does not apply to workers' compensation, medical malpractice, fidelity, suretyship, boiler and machinery, property or casualty insurance.

[1999, c. 742, §19 (NEW) .]

13. Limitation on remedy. The cause of action under this section is the sole and exclusive private remedy under state law for an enrollee against a carrier for its health care treatment decisions that affect the quality of the diagnosis, care or treatment provided to an enrollee, except that this subsection may not be construed to prohibit an enrollee or an enrollee's authorized representative from seeking other remedies specifically available under other provisions of this Title.

[1999, c. 742, §19 (NEW) .]

14. Wrongful death action. Notwithstanding subsection 13, an enrollee or an enrollee's authorized representative may bring a cause of action against a carrier for its health care treatment decisions to seek a remedy under either this section or under Title 18-A, section 2-804, but may not seek remedies under both this section and Title 18-A, section 2-804.

[1999, c. 742, §19 (NEW) .]

SECTION HISTORY

1999, c. 742, §19 (NEW). 2007, c. 199, Pt. B, §18 (AMD).

§4314. ACCESS TO EYE CARE PROVIDERS

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Eye care provider" means a participating provider who is an optometrist licensed to practice optometry pursuant to Title 32, chapter 34-A, or an ophthalmologist licensed to practice medicine pursuant to Title 32, chapter 48. [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF) .]

B. "Eye care services" means those urgent health care services related to the examination, diagnosis, treatment and management of conditions, illnesses and diseases of the eye and related structures that are provided to treat conditions, illnesses or diseases of the eye that if not treated within 24 hours present a serious risk of harm. [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF) .]

[2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF) .]

2. Coverage of eye care services. A carrier that provides coverage for eye care services as part of a health plan shall provide coverage for eye care services in accordance with the following.

A. An enrollee may receive eye care services from an eye care provider participating in the enrollee's health plan without the prior approval or authorization of the enrollee's primary care provider for a maximum of 2 visits, one initial visit and one follow-up visit, for each occurrence requiring urgent care as described in subsection 1, paragraph B. A carrier may not retrospectively deny coverage under this section on the basis that the eye care services received by the enrollee did not meet the requirements of subsection 1, paragraph B. In order to receive continuing benefits for treatment related to the initial visit, an enrollee must receive the approval of the enrollee's primary care provider for any visit after the 2nd visit. Within 3 working days of the initial visit, the eye care provider shall send to the enrollee's primary care provider a report containing the enrollee's complaint, related history, examination results, initial diagnosis and recommendations for treatment. If the eye care provider does not send a report to the primary care provider within 3 working days, the carrier is not obligated to provide benefits for the self-referred visits under this paragraph and the enrollee is not liable to the eye care provider for any unpaid fees. [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF) .]

B. A carrier shall ensure that all eye care providers participating in the carrier's health plans are included on any publicly accessible list of participating providers for the carrier. [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF) .]

C. A carrier shall allow each eye care provider participating in the carrier's health plans to furnish covered eye care services to enrollees without discrimination between classes of eye care providers and to provide the eye care services permitted by the eye care provider's license. [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

[2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF) .]

3. Prohibitions. A carrier may not:

A. Impose a deductible or coinsurance for eye care services that is greater than the deductible or coinsurance imposed for other health care services under a health plan; or [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

B. Require an eye care provider to hold hospital privileges as a condition of participation as a provider under a health plan. [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

[2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF) .]

4. Construction. This section may not be construed as:

A. Requiring coverage for routine eye examinations; [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

B. Creating coverage for any health care service that is not otherwise covered under the terms of a health plan; [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

C. Requiring a carrier to include as a participating provider every willing provider or health care professional who meets the terms and conditions of a health plan; [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

D. Preventing an enrollee from seeking eye care services from the enrollee's primary care provider in accordance with the terms of the enrollee's health plan; [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

E. Increasing or decreasing the scope of practice of optometry or ophthalmology as defined in Title 32; [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

F. Requiring eye care services to be provided in a hospital or similar health care facility; or [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

G. Notwithstanding the definition of eye care services in subsection 1, paragraph B, prohibiting a carrier from requiring an enrollee to receive prior approval or authorization from a primary care provider for any subsequent surgical procedures. [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

[2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF) .]

5. Application. The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §33 (NEW) .]

SECTION HISTORY

2001, c. 408, §1 (NEW). 2001, c. 408, §2 (AFF). 2003, c. 517, §B33 (AMD).

§4315. COVERAGE OF PROSTHETIC DEVICES

1. Definition. As used in this section, "prosthetic device" means an artificial device to replace, in whole or in part, an arm or a leg.

[2003, c. 459, §1 (NEW); 2003, c. 459, §2 (AFF) .]

2. Required coverage. A carrier shall provide coverage for prosthetic devices in all health plans that, at a minimum, equals, except as provided in subsection 8, the coverage and payment for prosthetic devices provided under federal laws and regulations for the aged and disabled pursuant to 42 United States Code, Sections 1395k, 1395l and 1395m and 42 Code of Federal Regulations, Sections 414.202, 414.210, 414.228 and 410.100. Covered benefits must be provided for a prosthetic device determined by the enrollee's provider, in accordance with section 4301-A, subsection 10-A, to be the most appropriate model that adequately meets the medical needs of the enrollee.

[2003, c. 688, Pt. I, §1 (AMD) .]

3. Prior authorization. A carrier may require prior authorization for prosthetic devices in the same manner as prior authorization is required for any other covered benefit.

[2003, c. 459, §1 (NEW); 2003, c. 459, §2 (AFF) .]

4. Repair or replacement. Coverage under this section must also be provided for repair or replacement of a prosthetic device if repair or replacement is determined appropriate by the enrollee's provider.

[2003, c. 459, §1 (NEW); 2003, c. 459, §2 (AFF) .]

5. Coverage under managed care plan. If coverage under this section is provided through a managed care plan, a carrier may require that prosthetic services be rendered by a provider who contracts with the carrier and that a prosthetic device be provided by a vendor designated by the carrier.

[2003, c. 459, §1 (NEW); 2003, c. 459, §2 (AFF) .]

6. Exclusions. Coverage is not required pursuant to this section for a prosthetic device that is designed exclusively for athletic purposes.

[2009, c. 603, §1 (AMD); 2009, c. 603, §2 (AFF) .]

7. Application. The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §34 (NEW) .]

8. Health savings accounts. Benefits for prosthetic devices under health plans issued for use in connection with health savings accounts as authorized under Title XII of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 may be subject to the same deductibles and out-of-pocket limits that apply to overall benefits under the contract.

[2003, c. 688, Pt. I, §2 (NEW) .]

SECTION HISTORY

2003, c. 459, §1 (NEW). 2003, c. 459, §2 (AFF). 2003, c. 517, §B34 (AMD). 2003, c. 688, §§11,2 (AMD). 2009, c. 603, §1 (AMD). 2009, c. 603, §2 (AFF).

§4316. COVERAGE FOR TELEMEDICINE SERVICES

1. Definition. For the purposes of this section, "telemedicine," as it pertains to the delivery of health care services, means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. "Telemedicine" does not include the use of audio-only telephone, facsimile machine or e-mail.

[2009, c. 169, §1 (NEW) .]

2. Coverage of telemedicine services. A carrier offering a health plan in this State may not deny coverage on the basis that the coverage is provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a health care provider. Coverage for health care services provided through telemedicine must be determined in a manner consistent with coverage for health care services provided through in-person consultation. A carrier may offer a health plan containing a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

[2009, c. 169, §1 (NEW) .]

SECTION HISTORY

2009, c. 169, §1 (NEW) .

§4317. PHARMACY PROVIDERS

1. Contracts with pharmacy providers. Notwithstanding section 2672, section 4307, subsection 3 and Title 32, chapter 117, subchapter 8, a carrier that provides coverage for prescription drugs as part of a health plan may not refuse to contract with a pharmacy provider that is qualified and is willing to meet the terms and conditions of the carrier's criteria for pharmacy participation as stipulated in the carrier's contractual agreement with its pharmacy providers.

This subsection may not be construed to limit a carrier's ability to offer an enrollee incentives, including variations in premiums, deductibles, copayments or coinsurance or variations in the quantities of medications available to the enrollee, to encourage the use of certain preferred pharmacy providers as long as the carrier makes the terms applicable to the preferred pharmacy providers available to all pharmacy providers. For purposes of this subsection, a preferred pharmacy provider is any pharmacy willing to meet the specified terms, conditions and price that the carrier may require for its preferred pharmacy providers.

[2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF) .]

2. Prompt payment of claims. Notwithstanding section 2436, the following provisions apply to the payment of claims submitted to a carrier by a pharmacy provider.

A. For purposes of this subsection, the following terms have the following meanings.

(1) "Applicable number of calendar days" means:

- (a) With respect to claims submitted electronically, 21 days; and
- (b) With respect to claims submitted otherwise, 30 days.

(2) "Clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this section. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF) .]

B. A contract entered into by a carrier with a pharmacy provider with respect to a prescription drug plan offered by a carrier must provide that payment is issued, mailed or otherwise transmitted with respect to all clean claims submitted by a pharmacy provider, other than a pharmacy that dispenses drugs by mail order only or a pharmacy located in, or under contract with, a long-term care facility, within the applicable number of calendar days after the date on which the claim is received. For purposes of this subsection, a claim is considered to have been received:

(1) With respect to claims submitted electronically, on the date on which the claim is transferred; and

(2) With respect to claims submitted otherwise, on the 5th day after the postmark date of the claim or the date specified in the time stamp of the transmission of the claim. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

C. If payment is not issued, mailed or otherwise transmitted by the carrier within the applicable number of calendar days after a clean claim is received, the carrier shall pay interest to the pharmacy provider at the rate of 18% per annum. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

D. A claim is considered to be a clean claim if the carrier involved does not provide notice to the pharmacy provider of any deficiency in the claim within 10 days after the date on which an electronically submitted claim is received or within 15 days after the date on which a claim submitted otherwise is received. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

E. If a carrier determines that a submitted claim is not a clean claim, the carrier shall immediately notify the pharmacy provider of the determination. The notice must specify all defects or improprieties in the claim and list all additional information or documents necessary for the proper processing and payment of the claim. If a pharmacy provider receives notice from a carrier that a claim has been determined to not be a clean claim, the pharmacy provider shall take steps to correct that claim and then resubmit the claim to the carrier for payment. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

F. A claim resubmitted to a carrier with additional information pursuant to paragraph E is considered to be a clean claim if the carrier does not provide notice to the pharmacy provider of any defect or impropriety in the claim within 10 days of the date on which additional information is received if the claim is resubmitted electronically or within 15 days of the date on which additional information is received if the claim is resubmitted otherwise. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

G. A claim submitted to a carrier that is not paid by the carrier or contested by the plan sponsor within the applicable number of calendar days after the date on which the claim is received by the carrier is considered to be a clean claim and must be paid by the carrier. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

H. Payment of a clean claim under this subsection is considered to have been made on the date on which the payment is transferred with respect to claims paid electronically and on the date on which the payment is submitted to the United States Postal Service or common carrier for delivery with respect to claims paid otherwise. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

I. A carrier shall pay all clean claims submitted electronically by electronic transfer of funds if the pharmacy provider so requests or has so requested previously. In the case when the payment is made electronically, remittance may be made by the carrier electronically. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

[2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF) .]

3. Exception. Subsections 1 and 2 do not apply to any medical assistance or public health programs administered by the Department of Health and Human Services, including, but not limited to, the Medicaid program and the elderly low-cost drug program under Title 22, section 254-D.

[2011, c. 443, §5 (AMD) .]

4. Participation in contracts . A pharmacy benefits manager may not require a pharmacist or pharmacy to participate in one network in order to participate in another network. The pharmacy benefits manager may not exclude an otherwise qualified pharmacist or pharmacy from participation in one network solely because the pharmacist or pharmacy declined to participate in another network managed by the pharmacy benefits manager.

[2011, c. 443, §6 (NEW) .]

5. Prohibition. The written contract between a carrier and a pharmacy benefits manager may not provide that the pharmacist or pharmacy is responsible for the actions of the insurer or a pharmacy benefits manager.

[2011, c. 443, §6 (NEW) .]

6. Pharmacy benefits manager duties. All contracts must provide that, when the pharmacy benefits manager receives payment for the services of a pharmacist or pharmacy, the pharmacy benefits manager shall distribute the funds in accordance with the time frames provided in this subchapter.

[2011, c. 691, Pt. A, §23 (AMD) .]

7. Complaints, grievances and appeals. A pharmacy benefits manager may not terminate the contract of or penalize a pharmacist or pharmacy solely as a result of the pharmacist's or pharmacy's filing of a complaint, grievance or appeal. This subsection is not intended to restrict the pharmacy's and pharmacy benefits manager's ability to enter into agreements that allow for mutual termination without cause.

[2011, c. 443, §6 (NEW) .]

8. Denial or limitation of benefits. A pharmacy's benefits manager may not terminate the contract of or penalize a pharmacist or pharmacy for expressing disagreement with a carrier's decision to deny or limit benefits to an enrollee or because the pharmacist or pharmacy assists the enrollee to seek reconsideration of the carrier's decision or because the pharmacist or pharmacy discusses alternative medications.

[2011, c. 443, §6 (NEW) .]

9. Written notice required. At least 60 days before a pharmacy's benefits manager terminates a pharmacy's or pharmacist's participation in the pharmacy benefits manager's plan or network, the pharmacy benefits manager shall give the pharmacy or pharmacist a written explanation of the reason for the termination, unless the termination is based on:

A. The loss of the pharmacy's license or the pharmacist's license to practice pharmacy or cancellation of professional liability insurance; or [2011, c. 443, §6 (NEW) .]

B. A finding of fraud. [2011, c. 443, §6 (NEW) .]

At least 60 days before a pharmacy or pharmacist terminates its participation in a pharmacy benefits manager's plan or network, the pharmacy or pharmacist shall give the pharmacy benefits manager a written explanation of the reason for the termination.

[2011, c. 443, §6 (NEW) .]

10. Audits. Notwithstanding any other provision of law, when an on-site audit of the records of a pharmacy is conducted by a pharmacy benefits manager, the audit must be conducted in accordance with the following criteria.

- A. A finding of overpayment or underpayment must be based on the actual overpayment or underpayment and not a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs, unless the projected overpayment or denial is a part of a settlement agreed to by the pharmacy or pharmacist. [2011, c. 443, §6 (NEW).]
- B. The auditor may not use extrapolation in calculating recoupments or penalties. [2011, c. 443, §6 (NEW).]
- C. Any audit that involves clinical or professional judgment must be conducted by or in consultation with a pharmacist. [2011, c. 443, §6 (NEW).]
- D. Each entity conducting an audit shall establish an appeals process under which a pharmacy may appeal an unfavorable preliminary audit report to the entity. [2011, c. 443, §6 (NEW).]
- E. This subsection does not apply to any audit, review or investigation that is initiated based on or involves suspected or alleged fraud, willful misrepresentation or abuse. [2011, c. 443, §6 (NEW).]
- F. Prior to an audit, the entity conducting an audit shall give the pharmacy 10 days' advance written notice of the audit and the range of prescription numbers and the range of dates included in the audit. [2013, c. 71, §1 (NEW).]
- G. A pharmacy has the right to request mediation by a private mediator, agreed upon by the pharmacy and the pharmacy benefits manager, to resolve any disagreements. A request for mediation does not waive any existing rights of appeal available to a pharmacy under this subsection or subsection 11. [2013, c. 71, §1 (NEW).]
- H. The requirements of section 4303, subsection 10 apply to claims audited under this subsection. [2013, c. 71, §1 (NEW).]

[2013, c. 71, §1 (AMD) .]

11. Audit information and reports. A preliminary audit report must be delivered to the pharmacy within 60 days after the conclusion of the audit under subsection 10. A pharmacy must be allowed at least 30 days following receipt of the preliminary audit to provide documentation to address any discrepancy found in the audit. A final audit report must be delivered to the pharmacy within 90 days after receipt of the preliminary audit report or final appeal, whichever is later. A charge-back, recoupment or other penalty may not be assessed until the appeal process provided by the pharmacy benefits manager has been exhausted and the final report issued. Except as provided by state or federal law, audit information may not be shared. Auditors may have access only to previous audit reports on a particular pharmacy conducted by that same entity.

§4317. Prohibition against maximum aggregate benefit provisions

(As enacted by PL 2009, c. 588, §1 and affected by §3 is REALLOCATED TO TITLE 24-A, SECTION 4318)

[2011, c. 443, §6 (NEW) .]

SECTION HISTORY

RR 2009, c. 2, §70 (RAL). 2009, c. 519, §1 (NEW). 2009, c. 519, §2 (AFF). 2009, c. 588, §1 (NEW). 2009, c. 588, §3 (AFF). 2011, c. 443, §§5, 6 (AMD). 2011, c. 691, Pt. A, §23 (AMD). 2013, c. 71, §1 (AMD).

§4317-A. PRESCRIPTION DRUG COVERAGE; OUT-OF-POCKET EXPENSES FOR COINSURANCE

1. Out-of-pocket expenses for coinsurance within health plan's total limit. If a carrier that provides coverage for prescription drugs does not include prescription drugs subject to coinsurance under the total out-of-pocket limit for all benefits provided under a health plan, the carrier shall establish a separate out-of-pocket limit not to exceed \$3,500 per year for prescription drugs subject to coinsurance provided under a health plan to the extent not inconsistent with the federal Affordable Care Act.

[2011, c. 611, §1 (NEW); 2011, c. 611, §2 (AFF) .]

2. Adjustment of out-of-pocket limits. A carrier may adjust an out-of-pocket limit, as long as any limit for prescription drugs for coinsurance does not exceed \$3,500, to minimize any premium increase that might otherwise result from the requirements of this section. Any adjustment made by a carrier pursuant to this subsection is considered a minor modification under section 2850-B.

[2011, c. 611, §1 (NEW); 2011, c. 611, §2 (AFF) .]

3. Construction. This section may not be construed to prohibit or limit a carrier's ability to establish specialty tiers for prescription drug coverage, to make determinations of medical necessity or to enforce procedures regarding prior authorization or utilization review in accordance with this chapter.

[2011, c. 611, §1 (NEW); 2011, c. 611, §2 (AFF) .]

4. Terms consistent with federal law. For the purposes of this section, the use of the terms "coinsurance" and "out-of-pocket limit" by a carrier must be consistent with the definitions of those terms as prescribed by the Secretary of the United States Department of Health and Human Services pursuant to Section 2715 of the federal Affordable Care Act.

[2011, c. 611, §1 (NEW); 2011, c. 611, §2 (AFF) .]

SECTION HISTORY

2011, c. 611, §1 (NEW). 2011, c. 611, §2 (AFF).

§4317-B. ORALLY ADMINISTERED CANCER THERAPY

1. Coverage. A carrier that provides coverage for cancer chemotherapy treatment shall provide coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is equivalent to the coverage provided for intravenously administered or injected anticancer medications. An increase in patient cost sharing for anticancer medications may not be used to achieve compliance with this section.

[2013, c. 449, §1 (NEW); 2013, c. 449, §2 (AFF) .]

2. Construction. This section may not be construed to prohibit or limit a carrier's ability to establish a prescription drug formulary or to require a carrier to cover an orally administered anticancer medication on the sole basis that it is an alternative to an intravenously administered or injected anticancer medication.

[2013, c. 449, §1 (NEW); 2013, c. 449, §2 (AFF) .]

SECTION HISTORY

2013, c. 449, §1 (NEW). 2013, c. 449, §2 (AFF).

§4318. PROHIBITION AGAINST MAXIMUM AGGREGATE BENEFIT PROVISIONS

(REALLOCATED FROM TITLE 24-A, SECTION 4317)

1. Prohibition. An individual or group health plan issued or renewed by a carrier on or after the effective date of this section may not include a provision in a policy, contract, certificate or agreement that purports to terminate payment of any additional claims for coverage of health care services after a defined maximum aggregate dollar amount of claims for coverage of health care services on an annual, lifetime or other basis has been paid under the health plan for coverage of an insured individual, family or group.

[2009, c. 2, §70 (RAL) .]

2. Specific benefits. This section may not be construed to limit the ability of a carrier to offer a health plan that limits benefits under the health plan for specified health care services on an annual basis.

[2009, c. 2, §70 (RAL) .]

3. Exceptions. This section does not apply to:

A. An individual health plan in effect on the effective date of this section with an annual or lifetime maximum aggregate benefit limit of less than \$1,000,000; [2009, c. 2, §70 (RAL) .]

B. A health plan designed for an employee who works on a part-time, temporary or seasonal basis or designed as short-term coverage for an employee who is fulfilling a waiting period for coverage under another employer-sponsored benefit plan; [2009, c. 2, §70 (RAL) .]

C. An individual health plan in effect on the effective date of this section issued pursuant to a conversion privilege in a group health insurance policy subject to section 2809-A; [2009, c. 2, §70 (RAL) .]

D. A pilot project to offer an individual health plan to a person under 30 years of age pursuant to section 2736-C, subsection 10; and [2009, c. 2, §70 (RAL) .]

E. Blanket health insurance as defined in section 2813. [2009, c. 2, §70 (RAL) .]

[2009, c. 2, §70 (RAL) .]

4. Disclosure. A health plan issued after the effective date of this section that includes an annual or lifetime maximum aggregate benefit limit as permitted under subsection 3 and under section 4320 must include a disclosure of the applicable limit on the face page of the individual policy or group certificate. The disclosure must be printed in a font that is larger or bolder than the font used in the body of the face page.

[2011, c. 364, §33 (AMD) .]

SECTION HISTORY

RR 2009, c. 2, §70 (RAL). 2011, c. 364, §33 (AMD).

§4319. REBATES

1. Rebates required. Carriers must provide rebates in the large group, small group and individual markets to the extent required by the federal Affordable Care Act and federal regulations adopted pursuant thereto if the medical loss ratio under subsection 2 is less than the minimum medical loss ratio under subsection 3.

[2011, c. 90, Pt. D, §5 (NEW) .]

2. Medical loss ratio. For purposes of this section, the medical loss ratio is the ratio of the numerator to the denominator as described in paragraphs A and B, respectively, plus any credibility adjustment. The period for which the medical loss ratio is determined and the meaning of all terms used in this subsection must be in accordance with the federal Affordable Care Act and federal regulations adopted pursuant thereto. For the purposes of this subsection:

- A. The numerator is the amount expended on reimbursement for clinical services provided to enrollees and activities that improve health care quality; and [2011, c. 90, Pt. D, §5 (NEW).]
- B. The denominator is the total amount of premium revenue excluding federal and state taxes and licensing and regulatory fees paid and after accounting for payments or receipts for risk adjustment, risk corridors and reinsurance pursuant to federal law. [2011, c. 90, Pt. D, §5 (NEW).]

[2011, c. 90, Pt. D, §5 (NEW) .]

3. Minimum medical loss ratio. The minimum medical loss ratio is:

- A. In the large group market, 85%; [2011, c. 90, Pt. D, §5 (NEW).]
- B. In the small group market, 80%; and [2011, c. 90, Pt. D, §5 (NEW).]
- C. In the individual market, 80% or such lower minimum medical loss ratio as the Secretary of the United States Department of Health and Human Services determines based on a finding, pursuant to the federal Affordable Care Act and federal regulations adopted pursuant thereto, that an 80% minimum medical loss ratio might destabilize the individual market in this State. [2011, c. 90, Pt. D, §5 (NEW).]

[2011, c. 90, Pt. D, §5 (NEW) .]

SECTION HISTORY

2011, c. 90, Pt. D, §5 (NEW).

§4320. NO LIFETIME OR ANNUAL LIMITS ON HEALTH PLANS SUBJECT TO THE AFFORDABLE CARE ACT

Notwithstanding the requirements of section 4318, a carrier offering a health plan subject to the federal Affordable Care Act may not: [2011, c. 364, §34 (NEW).]

1. Establish lifetime limits. Establish lifetime limits on the dollar value of benefits for any participant or beneficiary; or

[2011, c. 364, §34 (NEW) .]

2. Establish annual limits. Establish annual limits on the dollar value of essential benefits, except that, prior to January 1, 2014, health plans may include restricted annual limits on essential benefits consistent with the requirements of the federal Affordable Care Act and may establish annual limits consistent with waivers granted by the Secretary of the United States Department of Health and Human Services.

§4320. Payment reform pilot projects

(As enacted by PL 2011, c. 270, §2 is REALLOCATED TO TITLE 24-A, SECTION 4320-H)

[2011, c. 364, §34 (NEW) .]

SECTION HISTORY

RR 2011, c. 1, §43 (RAL). 2011, c. 270, §2 (NEW). 2011, c. 364, §34 (NEW).

§4320-A. COVERAGE OF PREVENTIVE HEALTH SERVICES

Notwithstanding any other requirements of this Title, a carrier offering a health plan subject to the federal Affordable Care Act shall, at a minimum, provide coverage for and may not impose cost-sharing requirements for preventive services as required by the federal Affordable Care Act. [2011, c. 364, §34 (NEW).]

SECTION HISTORY

2011, c. 364, §34 (NEW).

§4320-B. EXTENSION OF DEPENDENT COVERAGE

A carrier offering a health plan subject to the requirements of the federal Affordable Care Act that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age, consistent with the federal Affordable Care Act. [2011, c. 364, §34 (NEW).]

SECTION HISTORY

2011, c. 364, §34 (NEW).

§4320-C. EMERGENCY SERVICES

If a carrier offering a health plan subject to the requirements of the federal Affordable Care Act provides or covers any benefits with respect to services in an emergency department of a hospital, the plan must cover emergency services in accordance with the requirements of the federal Affordable Care Act, including requirements that emergency services be covered without prior authorization and that cost-sharing requirements, expressed as a copayment amount or coinsurance rate, for out-of-network services are the same as requirements that would apply if such services were provided in network. [2011, c. 364, §34 (NEW).]

SECTION HISTORY

2011, c. 364, §34 (NEW).

§4320-D. COMPREHENSIVE HEALTH COVERAGE

Notwithstanding any other requirements of this Title, a carrier offering a health plan subject to the requirements of the federal Affordable Care Act shall, at a minimum, provide coverage that incorporates essential benefits and cost-sharing limitations consistent with the requirements of the federal Affordable Care Act. [2011, c. 364, §34 (NEW).]

SECTION HISTORY

2011, c. 364, §34 (NEW).

§4320-E. REINSURANCE, RISK CORRIDORS AND RISK ADJUSTMENT

1. Transitional reinsurance program. The superintendent shall establish a transitional reinsurance program for calendar years 2014, 2015 and 2016 as required by Section 1341 of the federal Affordable Care Act.

[2011, c. 364, §34 (NEW).]

2. Risk corridors. A carrier shall make any payments required under the risk corridors program established by the Secretary of the United States Department of Health and Human Services for calendar years 2014, 2015 and 2016 as required by Section 1342 of the federal Affordable Care Act.

[2011, c. 364, §34 (NEW) .]

3. Risk adjustment. The superintendent shall establish a risk adjustment program as required by Section 1343 of the federal Affordable Care Act.

[2011, c. 364, §34 (NEW) .]

SECTION HISTORY

2011, c. 364, §34 (NEW).

§4320-F. OVERSIGHT OF PLANS OFFERED ON THE AMERICAN HEALTH BENEFIT EXCHANGE AND THE SHOP EXCHANGE

1. Superintendent's authority preserved. Except as otherwise expressly provided by applicable law, the requirements established by this Title, Title 24 and rules adopted by the superintendent continue to apply to carriers and health plans and are not extinguished or modified in any way by:

A. Certification of a health plan as a qualified health plan or any other determination made by the American Health Benefit Exchange or the SHOP Exchange pursuant to the federal Affordable Care Act; or [2011, c. 364, §34 (NEW) .]

B. Recognition by the applicable federal agency of a carrier as a qualified nonprofit health insurance issuer or as an issuer of multistate qualified health plans, or of a health plan as a multistate qualified health plan, pursuant to the federal Affordable Care Act. [2011, c. 364, §34 (NEW) .]

[2011, c. 364, §34 (NEW) .]

2. Coordination with exchanges. The superintendent has all additional powers and duties conferred upon a state insurance regulator with respect to the American Health Benefit Exchange and the SHOP Exchange by the federal Affordable Care Act. The superintendent may enter into agreements with the American Health Benefit Exchange and the SHOP Exchange relating to coordination of responsibilities, and such agreements may provide for the superintendent to assume additional authority relating to the certification of qualified health plans or the authorization of a carrier to participate in the American Health Benefit Exchange or the SHOP Exchange.

[2011, c. 364, §34 (NEW) .]

SECTION HISTORY

2011, c. 364, §34 (NEW).

§4320-G. APPLICABILITY TO HEALTH PLANS GRANDFATHERED UNDER THE AFFORDABLE CARE ACT

A health plan that is exempt from certain requirements of the federal Affordable Care Act because it has grandfathered status is also exempt, to the same extent, from substantially similar provisions in this Title and Title 24 enacted after January 1, 2011, except to the extent that those provisions state that they apply to grandfathered health plans. [2011, c. 364, §34 (NEW) .]

SECTION HISTORY

2011, c. 364, §34 (NEW).

§4320-H. PAYMENT REFORM PILOT PROJECTS

(REALLOCATED FROM TITLE 24-A, SECTION 4320)

1. Pilot projects. Beginning March 1, 2012, the superintendent may authorize pilot projects in accordance with this subsection that allow a health insurance carrier that offers health plans in this State to implement payment reform strategies with providers through an accountable care organization to reduce costs and improve the quality of patient care. For purposes of this section, "accountable care organization" means a group of health care providers operating under a payment agreement to provide health care services to a defined set of individuals with established benchmarks for the quality and cost of those health care services consistent with federal law and regulation.

A. The superintendent may approve a pilot project between a carrier and an accountable care organization that utilizes payment methodologies and purchasing strategies, including, but not limited to: alternatives to fee-for-service models, such as blended capitation rates, episodes-of-care payments, medical home models and global budgets; pay-for-performance programs; tiering of providers; and evidence-based purchasing strategies. [2011, c. 1, §43 (RAL) .]

B. Prior to approving a pilot project, the superintendent shall consider whether the proposed pilot project is consistent with the principles for payment reform developed by the Advisory Council on Health Systems Development established under former Title 2, section 104. [2011, c. 1, §43 (RAL) .]

[2011, c. 1, §43 (RAL) .]

2. Rulemaking. The superintendent shall establish by rule procedures and policies that facilitate the implementation of a pilot project pursuant to this section, including, but not limited to, a process for a health insurance carrier's submitting a pilot project proposal and minimum requirements for approval of a pilot project. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A and must be adopted no later than December 1, 2011.

[2011, c. 1, §43 (RAL) .]

3. Report. Beginning in 2013, the superintendent shall report by March 1st annually to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters on the status of any pilot project approved by the superintendent pursuant to this section. The report must include an analysis of the cost and benefits of any approved pilot project in reducing health care costs, including any impact on premiums, and in improving the quality of care.

[2011, c. 1, §43 (RAL) .]

4. Evaluation. During the First Regular Session of the 129th Legislature, the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters shall conduct an evaluation of the effectiveness of any pilot project approved by the superintendent pursuant to this section and make a determination whether to continue, amend or repeal the authorization for the pilot project. The joint standing committee of the Legislature having jurisdiction over insurance and financial services matters may report out a bill based on the evaluation to the First Regular Session of the 129th Legislature.

[2011, c. 1, §43 (RAL) .]

5. Construction. This section may not be construed to restrict or limit the right of a carrier to engage in activities expressly permitted by this Title or to require a carrier to obtain prior approval as a pilot project to engage in those activities.

[2011, c. 1, §43 (RAL) .]

SECTION HISTORY

RR 2011, c. 1, §43 (RAL).

§4320-I. COVERAGE FOR THE COST OF TESTING FOR BONE MARROW DONATION SUITABILITY

1. Required coverage. A carrier offering a health plan in this State shall provide coverage for laboratory fees up to \$150 arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability in accordance with the following requirements:

A. The enrollee covered under the health plan must meet the criteria for testing established by the National Marrow Donor Program, or its successor organization; [2013, c. 603, §1 (NEW); 2013, c. 603, §2 (AFF).]

B. The testing must be performed in a facility that is accredited by a national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is certified under the federal Clinical Laboratories Improvement Act of 1967, 42 United States Code, Section 263a; [2013, c. 603, §1 (NEW); 2013, c. 603, §2 (AFF).]

C. At the time of the testing, the enrollee covered under the health plan must complete and sign an informed consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program, or its successor organization, and acknowledges a willingness to be a bone marrow donor if a suitable match is found; and [2013, c. 603, §1 (NEW); 2013, c. 603, §2 (AFF).]

D. The carrier may limit each enrollee to one test per lifetime. [2013, c. 603, §1 (NEW); 2013, c. 603, §2 (AFF).]

[2013, c. 603, §1 (NEW); 2013, c. 603, §2 (AFF) .]

2. Prohibition on cost-sharing. A carrier may not impose any deductible, copayment, coinsurance or other cost-sharing requirement on an enrollee for the coverage required under this section.

[2013, c. 603, §1 (NEW); 2013, c. 603, §2 (AFF) .]

SECTION HISTORY

2013, c. 603, §1 (NEW). 2013, c. 603, §2 (AFF).

Subchapter 2: CONSUMER HEALTH CARE DIVISION HEADING: PL 1997, C. 792, §3 (NEW)

§4321. CONSUMER HEALTH CARE DIVISION

1. Division established. The Consumer Health Care Division, referred to in this section as the "division," is established within the Bureau of Insurance. The division shall work in coordination with other bureau sections and staff to accomplish the duties set forth in subsection 4.

[1997, c. 792, §3 (NEW) .]

2. Director. The Director of the Consumer Health Care Division, referred to in this section as the "director," is the head of the Consumer Health Care Division. The director is appointed by the superintendent and is subject to the approval of the Commissioner of Professional and Financial Regulation. The director is subject to the Civil Service Law.

[2005, c. 294, §23 (AMD) .]

3. Staff. The superintendent may hire or assign personnel as determined necessary to perform the duties of the division subject to the approval of the Commissioner of Professional and Financial Regulation and subject to the Civil Service Law. The personnel are supervised by the director in consultation with the superintendent. The qualifications of those personnel must reflect the needs and responsibilities relating to the division's duties under this subchapter.

[1997, c. 792, §3 (NEW) .]

4. Duties. The duties of the division include:

A. Providing access to the division through a toll-free number; [1997, c. 792, §3 (NEW) .]

B. Providing information to consumers regarding health care plan options and obtaining health care coverage and services. The division may not make any specific recommendations regarding commercially offered products; [1997, c. 792, §3 (NEW) .]

C. Assisting enrollees to understand their rights and responsibilities under health care plans; [1997, c. 792, §3 (NEW) .]

D. Providing information to consumers on health care plan performance by distributing materials and utilizing existing resources relating to health care plan performance; [1997, c. 792, §3 (NEW) .]

E. Providing assistance to enrollees with complaints relating to health care plans, when appropriate. The division may assist enrollees with quality-of-care complaints by coordinating with the appropriate state health professional licensing boards and other appropriate state and federal oversight bodies with authority over quality-of-care complaints. The division shall defer any issues of professional competence to the appropriate state health professional licensing boards; [1997, c. 792, §3 (NEW) .]

F. Collecting and disseminating information regarding health care plans, quality assurance programs and quality improvement and coordinating information with other public entities or agencies involved in the delivery, funding or regulation of health care; [1997, c. 792, §3 (NEW) .]

G. Acting as an information resource in the development of policies and programs that protect consumer interests and rights under health care plans by:

(1) Analyzing, evaluating and monitoring the development and implementation of federal, state and local laws, regulations, rules and other governmental policies and actions that pertain to the health, safety, welfare and rights of health care consumers; and

(2) Identifying practices and policies that may affect access to quality health care, including, but not limited to, practices relating to marketing of health care plans and accessibility of services and resources for under-served areas and vulnerable populations. The division may refer these issues to the appropriate state or federal regulatory agency with jurisdiction over these practices and policies; [1997, c. 792, §3 (NEW) .]

H. Promoting coordination between the division and other organizations that assist consumers, including, but not limited to, legal assistance providers serving low-income health care consumers and other health care consumers, health insurance counseling assistance programs, the long-term care ombudsman program pursuant to Title 22, section 5106, subsection 11-C and assistance programs for individuals with disabilities established under federal or state law; [1997, c. 792, §3 (NEW) .]

I. Collecting and disseminating information regarding the activities of the division; [1997, c. 792, §3 (NEW).]

J. Submitting an annual report by January 1st of each year to the Commissioner of Professional and Financial Regulation, the Consumer Health Care Division Advisory Council and the joint standing committee of the Legislature having jurisdiction over insurance matters describing the activities carried out by the division in the year for which the report is prepared, analyzing the data available to the division and evaluating the problems experienced by consumers; and [1997, c. 792, §3 (NEW).]

K. Performing other duties as the superintendent may prescribe. [1997, c. 792, §3 (NEW).]

[1997, c. 792, §3 (NEW) .]

SECTION HISTORY

1997, c. 792, §3 (NEW). 2005, c. 294, §23 (AMD).

§4322. CONSUMER HEALTH CARE DIVISION ADVISORY COUNCIL

(REPEALED)

SECTION HISTORY

1997, c. 792, §3 (NEW). 2003, c. 689, §B7 (REV). 2005, c. 294, §24 (RP).

Subchapter 3: DOWNSTREAM RISK HEADING: PL 1999, C. 609, §20 (NEW)

§4331. DEFINITIONS

As used in this subchapter, unless the context otherwise indicates, the following terms have the following meanings. [1999, c. 609, §20 (NEW).]

1. Bonus. "Bonus" means a payment a carrier makes to a downstream entity beyond any salary, fee-for-service payment, capitation or returned withhold.

[1999, c. 609, §20 (NEW) .]

2. Capitation. "Capitation" means a set dollar payment per patient per unit of time, usually per month, that a carrier pays a health care practitioner, institutional provider or downstream entity to cover a specified set of services and administrative costs without regard to the actual number or nature of services provided. The services covered may include the downstream entity's own services, referral services or all medical services.

[1999, c. 609, §20 (NEW) .]

3. Downstream entity. "Downstream entity" means a person other than a carrier that has assumed all or part of the insurance risk of one or more health plans under a contractual relationship with a carrier or another downstream entity. An employer exempt from the applicability of this chapter under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) is not considered a downstream entity.

[1999, c. 609, §20 (NEW) .]

4. Downstream risk arrangement. "Downstream risk arrangement" means an arrangement that transfers insurance risk from a carrier to a downstream entity.

[2003, c. 428, Pt. H, §6 (AMD) .]

5. Payments. "Payments" means any amounts the carrier pays the downstream entity for services the downstream entity furnishes directly, plus amounts paid for administration and amounts paid in whole or in part based on use and costs of referral services such as withhold amounts, bonuses based on referral levels and any other compensation to the downstream entity to influence the use of referral services. Bonuses and other compensation that are not based on referral levels, such as bonuses based solely on quality of care furnished, patient satisfaction and participation on committees, are not considered payments for purposes of this subchapter.

[1999, c. 609, §20 (NEW) .]

6. Physician group. "Physician group" means a partnership, association, corporation, individual practice association or other group of physicians that distributes income from the practice among members. An individual practice association is a physician group only if the association is composed of individual physicians and has no subcontracts with physician groups.

[1999, c. 609, §20 (NEW) .]

7. Potential payments. "Potential payments" means the maximum anticipated total amount, based on the most recent year's utilization and experience and any current or anticipated factors that may affect costs, to be paid for a defined set of referral services for the carrier's subscribers and for which the downstream entity assumes by contract financial risk, to some extent, for the costs of such services. The methodology for determining potential payments must be filed by the carrier with the bureau.

[1999, c. 609, §20 (NEW) .]

8. Referral services. "Referral services" means any specialty, inpatient, outpatient or laboratory services that a downstream entity orders or arranges, but does not furnish directly.

[1999, c. 609, §20 (NEW) .]

9. Risk-sharing arrangement. "Risk-sharing arrangement" means an arrangement between a carrier and a downstream entity in which the carrier continues to pay providers for a defined set of services subject to an annual reconciliation process in which costs incurred by the carrier are compared with budgeted or targeted amounts for such services and that may, if payments are different than the budgeted amount, create financial liability of the downstream entity to the carrier or the carrier to the downstream entity provided the carrier holds or retains control of any funds in excess of those required to satisfy current claims obligations or direct payment to providers for services rendered pending reconciliation.

[1999, c. 609, §20 (NEW) .]

10. Risk threshold. "Risk threshold" means the maximum risk, if the risk is based on referral services, to which a downstream entity may be exposed under a downstream risk arrangement without being at substantial financial risk.

[1999, c. 609, §20 (NEW) .]

11. Withhold. "Withhold" means a percentage of payments or set dollar amounts that a carrier deducts from a downstream entity's service fee, capitation or salary payment and that may or may not be returned to the downstream entity, depending on specific predetermined factors.

[1999, c. 609, §20 (NEW) .]

SECTION HISTORY

1999, c. 609, §20 (NEW). 2003, c. 428, §H6 (AMD).

§4332. SAFE HARBOR AND WAIVER

1. Authority for safe harbor. Notwithstanding any other provisions of this Title or Title 24, including, without limitation, sections 4341 and 4342, an arrangement between a carrier and a downstream entity with which the carrier has contracted to provide or arrange for the provision of services that allows the downstream entity to accept a limited degree of insurance risk is permitted and such a risk arrangement is deemed not to be engaging in the business of insurance by the downstream entity if:

A. The arrangement does not involve substantial insurance risk or substantial enrollment risk as described in section 4334; and [1999, c. 609, §20 (NEW).]

B. The arrangement meets the requirements of sections 4335 and 4336. [1999, c. 609, §20 (NEW).]

[1999, c. 609, §20 (NEW) .]

2. Waiver for downstream risk arrangements that exceed risk threshold described in section 4334.

Carriers and downstream entities that wish to develop downstream risk arrangements that exceed the risk threshold described in section 4334 may jointly request that the superintendent grant a waiver that allows the downstream entity to accept a limited degree of insurance risk without being licensed as an insurer, a health maintenance organization or an insurance administrator. The joint request for a waiver must include a plan for managing financial exposure, based upon reasonable enrollment and utilization projections and upon the contracts, parties and features proposed, sufficient to quantify in dollars per quarter and per annum all elements of downstream risk to be assumed by the downstream entity. All other risk arrangements are prohibited unless the arrangements meet the appropriate licensing standards or are expressly permitted by the superintendent.

[1999, c. 609, §20 (NEW) .]

3. Continuing obligation to subscribers. A carrier contracting with a downstream entity remains obligated to its subscribers for the delivery of health care benefits consistent with existing state law. The carrier remains responsible for compliance with all applicable laws.

[1999, c. 609, §20 (NEW) .]

4. Certain incentives prohibited. A downstream risk arrangement may not contain incentives for the downstream entity or participating provider to limit or deny medically necessary care to enrollees.

[1999, c. 609, §20 (NEW) .]

5. Requirements still applicable. The application of the safe harbor provisions in subsection 1 or a waiver of licensing requirements granted pursuant to this section does not exempt the downstream entity from any other licensure or prior approval requirements applicable to activities conducted by the downstream entity, including, but not limited to, utilization review licensure, insurance administrator licensure or preferred provider arrangement registration.

[1999, c. 609, §20 (NEW) .]

SECTION HISTORY

1999, c. 609, §20 (NEW).

§4333. REQUIREMENTS FOR DOWNSTREAM RISK ARRANGEMENTS

1. Permissible downstream risk arrangements. Downstream entities that do not exceed the risk threshold described in section 4334 may enter into downstream risk arrangements only if:

A. The requirements of section 4332, subsection 1 and sections 4335 and 4336 are met; and [1999 , c. 609 , §20 (NEW) .]

B. No specific payment is made directly or indirectly under the plan to a provider as an inducement to reduce or limit medically necessary services furnished to an enrollee. [1999 , c. 609 , §20 (NEW) .]

[1999 , c. 609 , §20 (NEW) .]

2. Prohibited downstream risk payments. A specific payment of any kind may not be made directly or indirectly under the incentive plan to a downstream entity as an inducement to reduce or limit covered medically necessary services under the carrier's contract furnished to an enrollee. Indirect payments include offerings of monetary value such as stock options or waivers of debt measured in the present or future.

[1999 , c. 609 , §20 (NEW) .]

3. Applicability. This section applies to risk arrangements between carriers and downstream entities with which they contract to provide medical services to enrollees. This section also applies to subcontracting arrangements.

[1999 , c. 609 , §20 (NEW) .]

SECTION HISTORY

1999 , c. 609 , §20 (NEW) .

§4334. SUBSTANTIAL INSURANCE RISK; SUBSTANTIAL ENROLLMENT RISK

1. Substantial insurance risk. Substantial insurance risk is risk based on the use or costs of referral services only, when the downstream entity is at risk for more than 25% of potential payments by the carrier to the downstream entity.

[1999 , c. 609 , §20 (NEW) .]

2. Substantial enrollment risk. Substantial enrollment risk exists when a carrier enters into a risk arrangement with a downstream entity involving more than 25% of the enrollees served by the carrier in the State unless the risk arrangement is a risk-sharing arrangement.

[1999 , c. 609 , §20 (NEW) .]

SECTION HISTORY

1999 , c. 609 , §20 (NEW) .

§4335. CONTRACTUAL PROVISIONS

Full copies of contracts and summary descriptions of contracts must be provided to the superintendent. The following provisions must be included in contracts between a carrier and a downstream entity: [1999 , c. 609 , §20 (NEW) .]

1. Enrollee not liable. A provision in all relevant contracts between a carrier and a downstream entity or between a downstream entity and a participating provider of health care services stating that if the carrier fails to pay for health care services as set forth in the contract, the enrollee may not be liable to the provider for any sums owed by the carrier;

[1999 , c. 609 , §20 (NEW) .]

2. Maintenance of books, accounts and records. A provision for the maintenance of books, accounts and records by the downstream entity and the carrier to verify that transactions, including the risk transfer, are clearly, accurately and completely recorded, in accordance with generally accepted accounting principles and disclosed in writing;

[1999, c. 609, §20 (NEW) .]

3. Prohibition on assignment of rights or obligations. A provision prohibiting the assignment of any rights or obligations under the contract in the absence of the consent of the carrier;

[1999, c. 609, §20 (NEW) .]

4. Right to object to subcontractor. A provision granting the carrier the right to be advised of and the right to object to any subcontractor with whom the downstream entity proposes to contract with respect to services required to be performed by the downstream entity under its contract with the carrier;

[1999, c. 609, §20 (NEW) .]

5. Termination of contract. A provision for the termination of the contract, including the right to immediately terminate the contract upon a valid order issued by the superintendent or another lawful authority;

[1999, c. 609, §20 (NEW) .]

6. Compliance with utilization review laws, rules and licensing requirements. A provision requiring the downstream entity to comply with utilization review laws, rules and licensing requirements appropriate to the functions the downstream entity has contracted to undertake on behalf of the carrier;

[1999, c. 609, §20 (NEW) .]

7. Ability to perform. A provision requiring the downstream entity to advise the carrier in a timely manner of relevant matters that may have a material effect on the downstream entity's ability to perform under the contract, including, but not limited to:

A. Whether the downstream entity or participating provider is subject to an administrative order, a cease and desist order, a fine or a license suspension; and [1999, c. 609, §20 (NEW) .]

B. Whether legal action has been taken that may have a material effect on the downstream entity's financial condition or the downstream entity's ability to perform under the contract; and [1999, c. 609, §20 (NEW) .]

[1999, c. 609, §20 (NEW) .]

8. Incorporation by reference. A provision requiring the contract between a carrier and a downstream entity to be attached to all contracts between the downstream entity and those of the entity's participating providers contractually obligated to provide services to the carrier's enrollees under the contract between the carrier and the downstream entity.

[1999, c. 609, §20 (NEW) .]

SECTION HISTORY

1999, c. 609, §20 (NEW).

§4336. DISCLOSURE REQUIREMENTS FOR ORGANIZATIONS WITH DOWNSTREAM RISK ARRANGEMENTS

1. Disclosure to superintendent. Each carrier shall provide information concerning the carrier's downstream risk arrangements as required or requested by the superintendent. The disclosure must contain the following information in sufficient detail to enable the superintendent to determine whether the risk arrangement complies with the following requirements:

A. Whether services not furnished by the downstream entity are covered by the risk arrangement. If the services furnished by the downstream entity are covered by the risk arrangement, disclosure of other aspects of the plan need not be made; [1999, c. 609, §20 (NEW).]

B. The type of risk arrangement; for example, withhold, bonus, capitation; [1999, c. 609, §20 (NEW).]

C. If the risk arrangement involves a withhold or bonus, the percent of the withhold or bonus; [1999, c. 609, §20 (NEW).]

D. The panel size, the number of enrollees covered by the downstream entity and the total number of enrollees covered by the carrier in the State; and [1999, c. 609, §20 (NEW).]

E. In the case of capitated downstream entities, capitation payments paid to primary care providers for the most recent year broken down by percent for primary care services, referral services to specialists, hospital services and other types of provider services, including, but not limited to, nursing home and home health agency services. [1999, c. 609, §20 (NEW).]

[1999, c. 609, §20 (NEW) .]

2. Annual disclosure. A carrier shall provide this information to the superintendent at least annually. A carrier shall provide the capitation data required under subsection 1 for the previous calendar year to the superintendent by April 1st of each year.

[1999, c. 609, §20 (NEW) .]

3. Disclosure to enrollees. A carrier shall provide the following information to any enrollee upon request:

A. Whether the prepaid plan uses a downstream risk arrangement that affects the use of referral services; and [1999, c. 609, §20 (NEW).]

B. The type of risk arrangement. [1999, c. 609, §20 (NEW).]

[1999, c. 609, §20 (NEW) .]

SECTION HISTORY

1999, c. 609, §20 (NEW).

§4337. REQUIREMENTS RELATED TO SUBCONTRACTING ARRANGEMENTS

1. Physician groups. A carrier that contracts with a downstream entity that places the individual physician members at substantial financial risk for services they do not furnish shall disclose to the superintendent any incentive plan between the downstream entity and the entity's individual physicians that bases compensation to the physician on the use or cost of services furnished to enrollees. The disclosure must include the information specified in section 4336, subsection 1.

[1999, c. 609, §20 (NEW) .]

2. Intermediate entities. A carrier that contracts with a downstream entity, other than a physician group, for the provision of services to enrollees shall disclose to the superintendent any risk arrangement between the entity and a physician or physician group that bases compensation to the physician or physician group on the use or cost of services furnished to enrollees. The disclosure must include the information required to be disclosed under section 4336, subsection 1.

[1999, c. 609, §20 (NEW) .]

3. Sanctions against the carrier. The superintendent may apply intermediate sanctions if the superintendent determines that a carrier fails to comply with the requirements of this section.

[1999, c. 609, §20 (NEW) .]

SECTION HISTORY

1999, c. 609, §20 (NEW).

§4338. DOWNSTREAM RISK ARRANGEMENTS THAT EXCEED RISK THRESHOLD DESCRIBED IN SECTION 4334

The superintendent may waive downstream risk arrangements from licensure requirements that exceed the risk threshold described in section 4334 if the downstream risk arrangement meets the contractual and disclosure requirements established under section 4332 and the criteria set forth in sections 4339 to 4342 and is determined by the superintendent not to prejudice enrollee interests. [1999, c. 609, §20 (NEW) .]

SECTION HISTORY

1999, c. 609, §20 (NEW).

§4339. CONTRACTUAL PROVISIONS TO DEMONSTRATE FINANCIAL VIABILITY

If a carrier applies for a waiver under section 4332, subsection 2, the carrier may demonstrate the financial viability and condition of the downstream entity through the terms of the contract, including one or more of the following: [1999, c. 609, §20 (NEW) .]

1. Books, accounts and records. A contractual provision authorizing the carrier to access the downstream entity's books, accounts and records according to terms and conditions on which the carrier and the downstream entity agree;

[1999, c. 609, §20 (NEW) .]

2. Financial statements. A contractual provision requiring the downstream entity to provide to the carrier interim unaudited financial statements on a regular and ongoing basis as well as an annual financial statement, accompanied by a certified public accountant's opinion, appropriate to the magnitude of risk involved;

[1999, c. 609, §20 (NEW) .]

3. Reserves. A contractual provision authorizing the carrier to receive information regarding the downstream entity's reserves;

[1999, c. 609, §20 (NEW) .]

4. Letter of credit. A contractual provision requiring the downstream entity to post a letter of credit or other acceptable financial security;

[1999, c. 609, §20 (NEW) .]

5. Fees. A contractual provision under which the carrier withholds fees payable to the downstream entity or to the providers for which it acts;

[1999, c. 609, §20 (NEW) .]

6. General liability insurance. A contractual provision requiring the downstream entity to carry general liability insurance and requiring participating providers to carry professional liability insurance in an amount and from an insurer mutually acceptable to the carrier and the downstream entity;

[1999, c. 609, §20 (NEW) .]

7. Surety bond. A contractual provision requiring the downstream entity to secure a surety bond to cover the downstream entity's performance under the contract; or

[1999, c. 609, §20 (NEW) .]

8. Excess of loss insurance. A contractual provision requiring the downstream entity to secure excess of loss insurance or reinsurance in an amount and from an insurer mutually acceptable to the carrier and the downstream entity.

[1999, c. 609, §20 (NEW) .]

SECTION HISTORY

1999, c. 609, §20 (NEW).

§4340. FINANCIAL VIABILITY

Each carrier and downstream entity requesting a waiver shall file with the superintendent a plan for managing financial exposure under those downstream risk arrangement contracts and thereafter operate in substantial conformance with the terms of that plan and of the corresponding waiver. At least 60 days before any material change in a filed and approved exposure management plan, the carrier and downstream entity shall file for the superintendent's review and approval a modified plan, along with any changes in related contracts. [1999, c. 609, §20 (NEW).]

SECTION HISTORY

1999, c. 609, §20 (NEW).

§4341. LIMITATIONS ON PREMIUM TRANSFER

The superintendent may deny a request for waiver based on any of the following characteristics: [1999, c. 609, §20 (NEW).]

1. Transfer of 30% of annual aggregate premium. A contract by which 30% or more of the carrier's annual aggregate premium with respect to a contract, plan or product is transferred to a single downstream entity. This transfer is the sum of capitated payments plus the sum of amounts returnable to the carrier through incentive payments or other risk adjustments; or

[1999, c. 609, §20 (NEW) .]

2. Transfer of 75% of annual aggregate premium. Multiple contracts by which 75% or more of the carrier's annual aggregate premium with respect to a contract, plan or product is transferred to one or more downstream entities. This transfer is the sum of capitated payments plus the sum of amounts returnable to the carrier through incentive payments or other risk adjustments.

[1999, c. 609, §20 (NEW) .]

SECTION HISTORY

1999, c. 609, §20 (NEW).

§4342. RELATED PROVISIONS

The superintendent may deny a request for waiver based on any of the following characteristics:

[1999, c. 609, §20 (NEW) .]

1. Carrier controlled. An arrangement with a downstream entity that has control of the carrier. "Control" has the same meaning as defined in section 222, subsection 2, paragraph B;

[1999, c. 609, §20 (NEW) .]

2. Transfer of claims processing, payment or adjudication. An arrangement by which the claims processing, claims payment or claims adjudication functions are transferred to the downstream entity from the carrier. This section may not be construed to authorize the superintendent to deny a request based on the transfer of utilization review functions from the carrier to the downstream entity;

[1999, c. 609, §20 (NEW) .]

3. Transfer of managerial control. An arrangement by which managerial control of the carrier's information system is transferred to the downstream entity;

[1999, c. 609, §20 (NEW) .]

4. Overlap between officers or directors. An arrangement in which there is overlap between the officers or directors of the downstream entity and the carrier; or

[1999, c. 609, §20 (NEW) .]

5. Transfer of more than 1/12 of annual capitated payments. An arrangement that transfers more than 1/12 of the annual capitated payments at one time to the downstream entity.

[1999, c. 609, §20 (NEW) .]

SECTION HISTORY

1999, c. 609, §20 (NEW).

§4343. RULES

The superintendent may adopt rules establishing application procedures and specific standards for meeting the requirements pursuant to this subchapter. Rules adopted pursuant to this subchapter are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A. [1999, c. 609, §20 (NEW) .]

SECTION HISTORY

1999, c. 609, §20 (NEW).

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